Equity-Centered Sterilization Counseling Evidence, Consent, and Practical Pearls

E. Bimla Schwarz, MD, MS, FACP

Finn Wilder-Piper, MSN, FNP-BC

Lindsey Wilder-Piper, MSN, WHNP-BC

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

CAPTC
California Prevention Training Center

February 20, 2026

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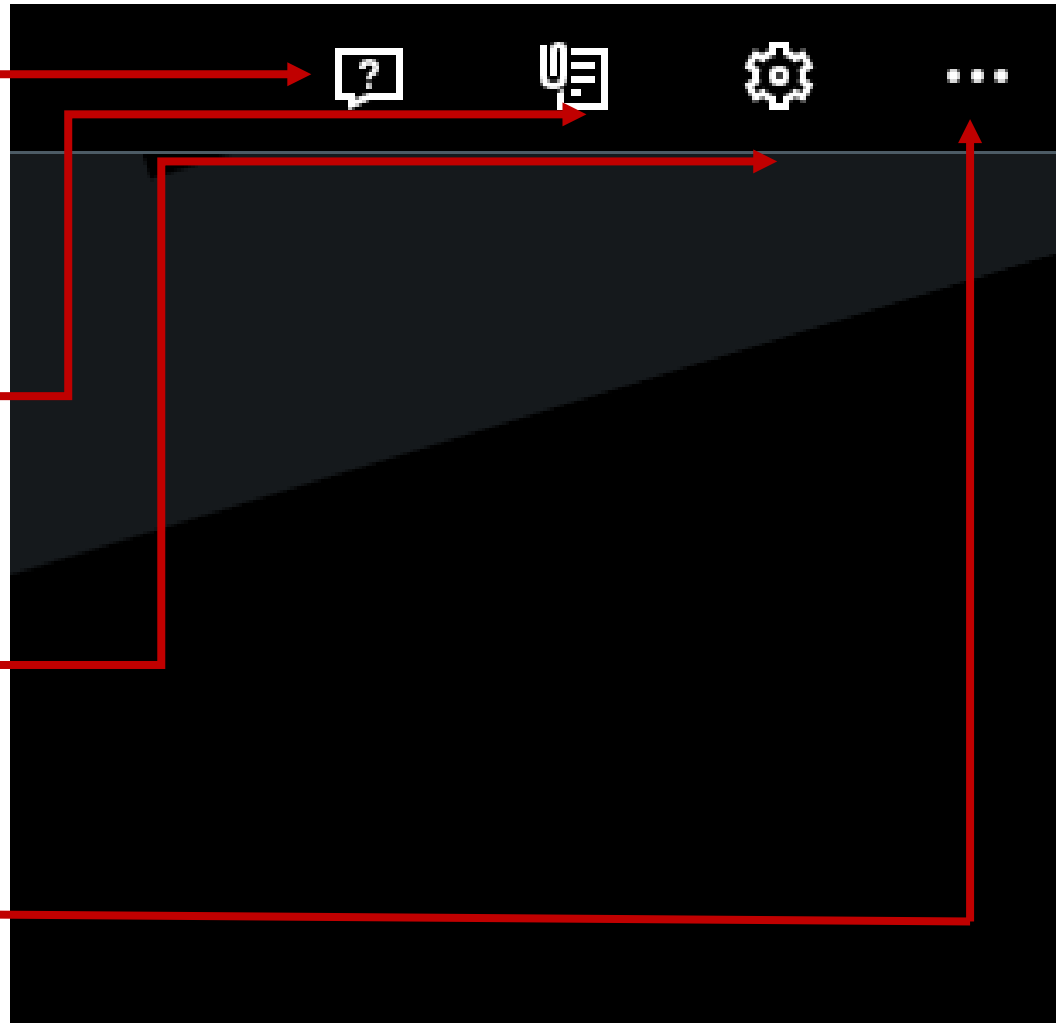

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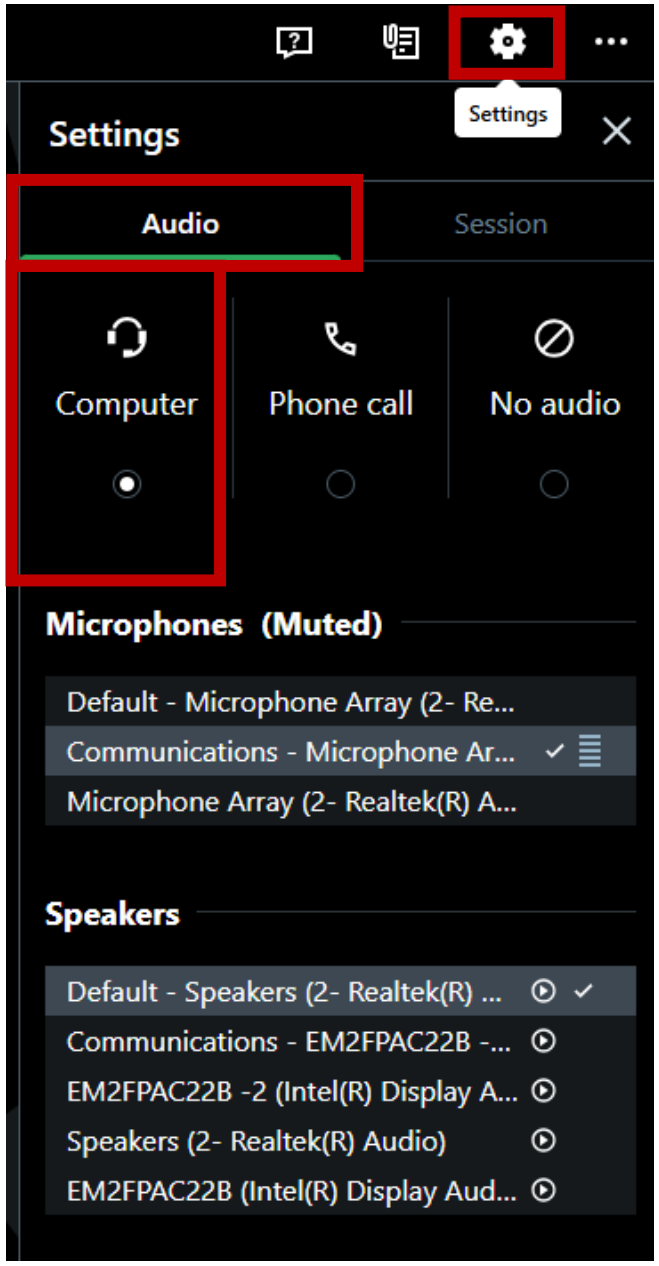

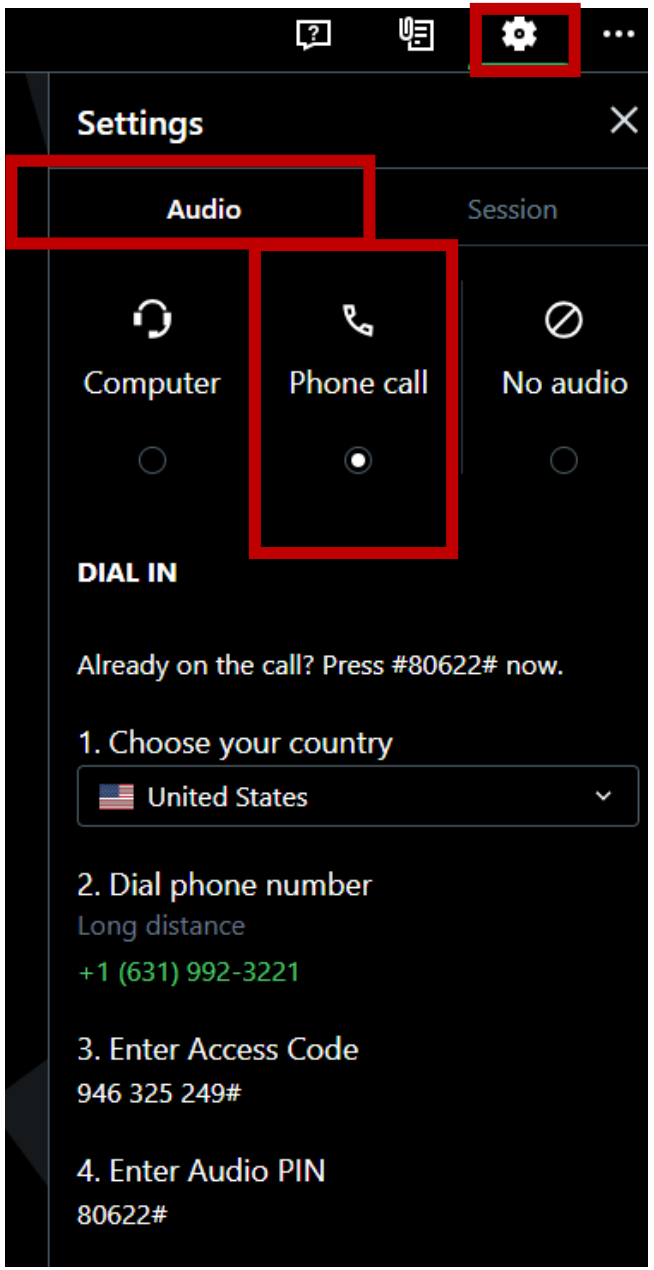

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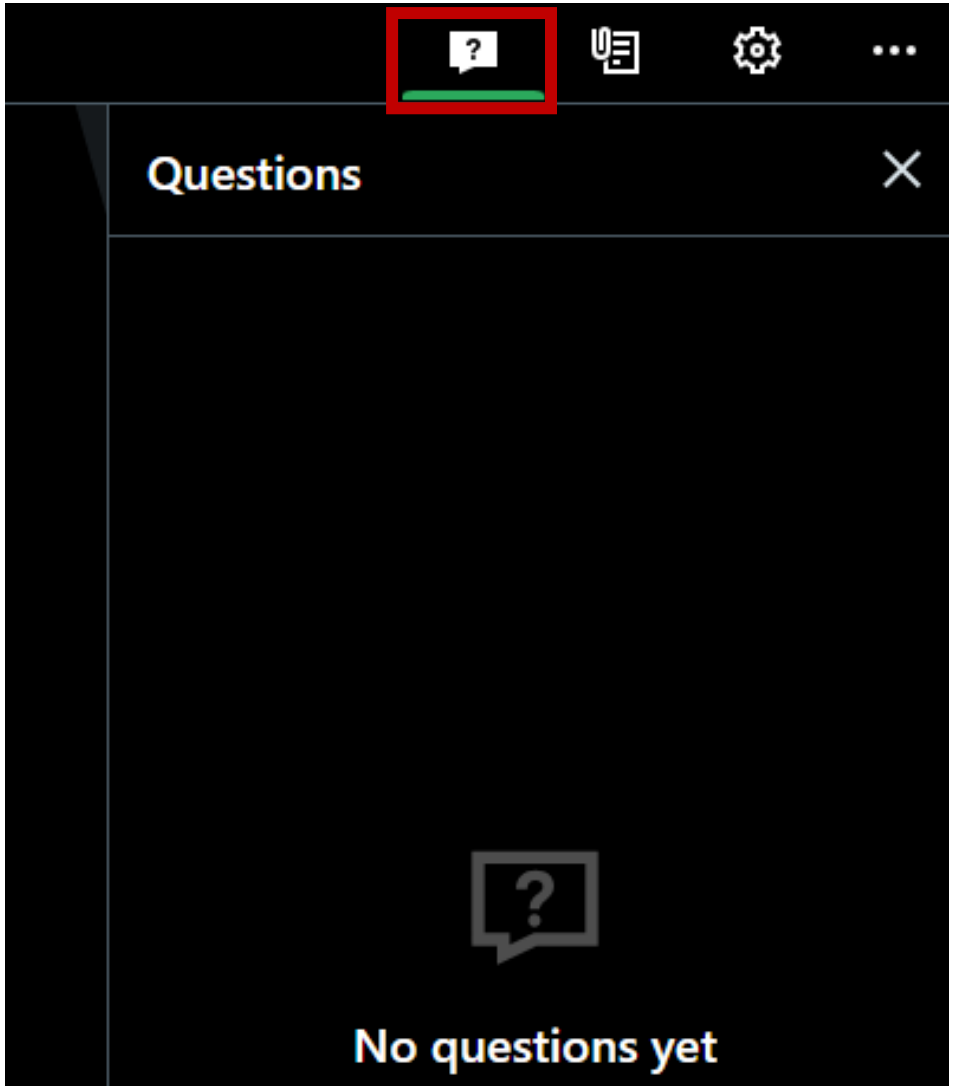

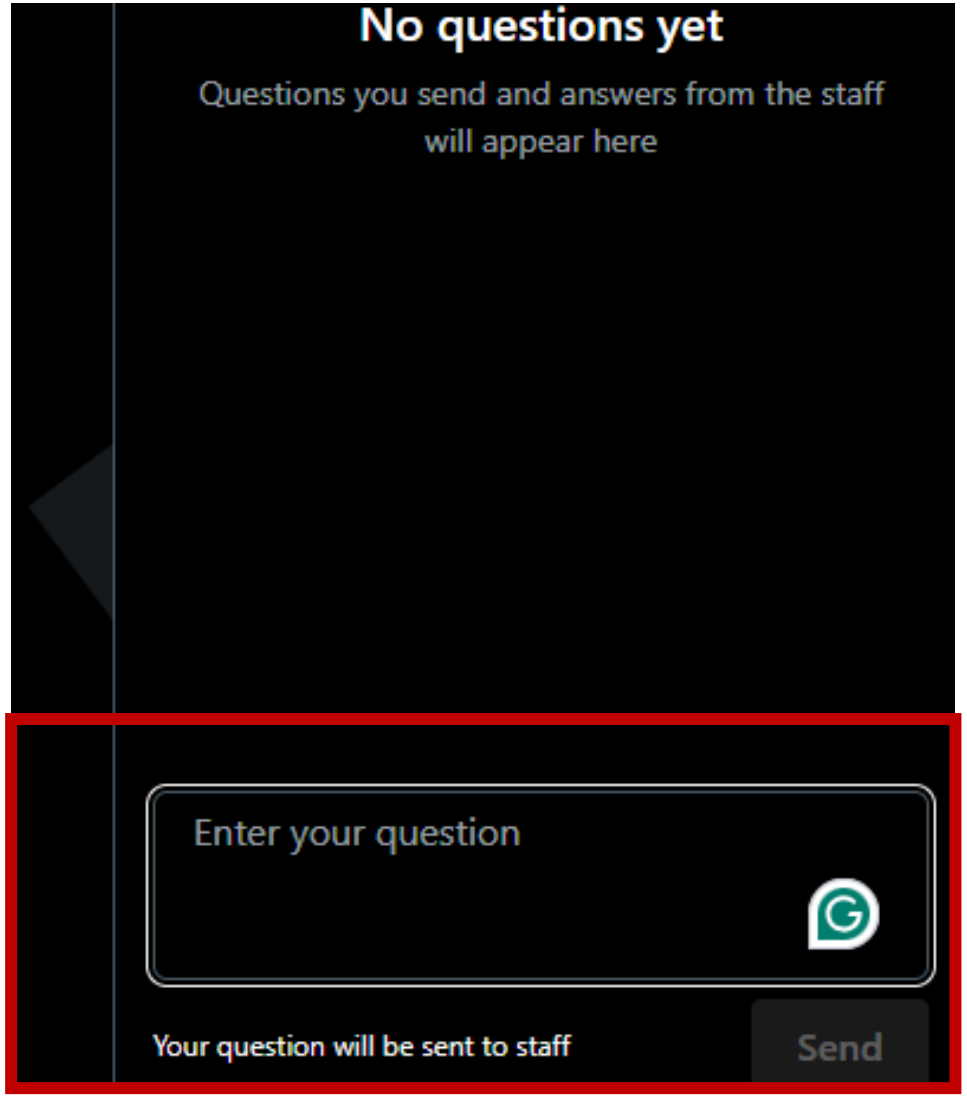

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Eleanor Bimla Schwarz, MD, MS, FACP (she/her)

- Professor of Medicine
- University of California, San Francisco (UCSF)
- Chief, Division of General Internal Medicine
- San Francisco General Hospital
- Fellow of the American College of Physicians

Finn Wilder-Piper, MSN, FNP-BC (they/them)

- Sexual and Reproductive Health Nurse Practitioner
- Maine Family Planning

Lindsey Wilder-Piper, MSN, WHNP-BC (she/they)

- Nurse Practitioner
- Joan G. Lovering Health Center
- Project Manager and Technical Assistant, Repro TLC
- Abortion Provider and Clinician Educator, HealthQuarters

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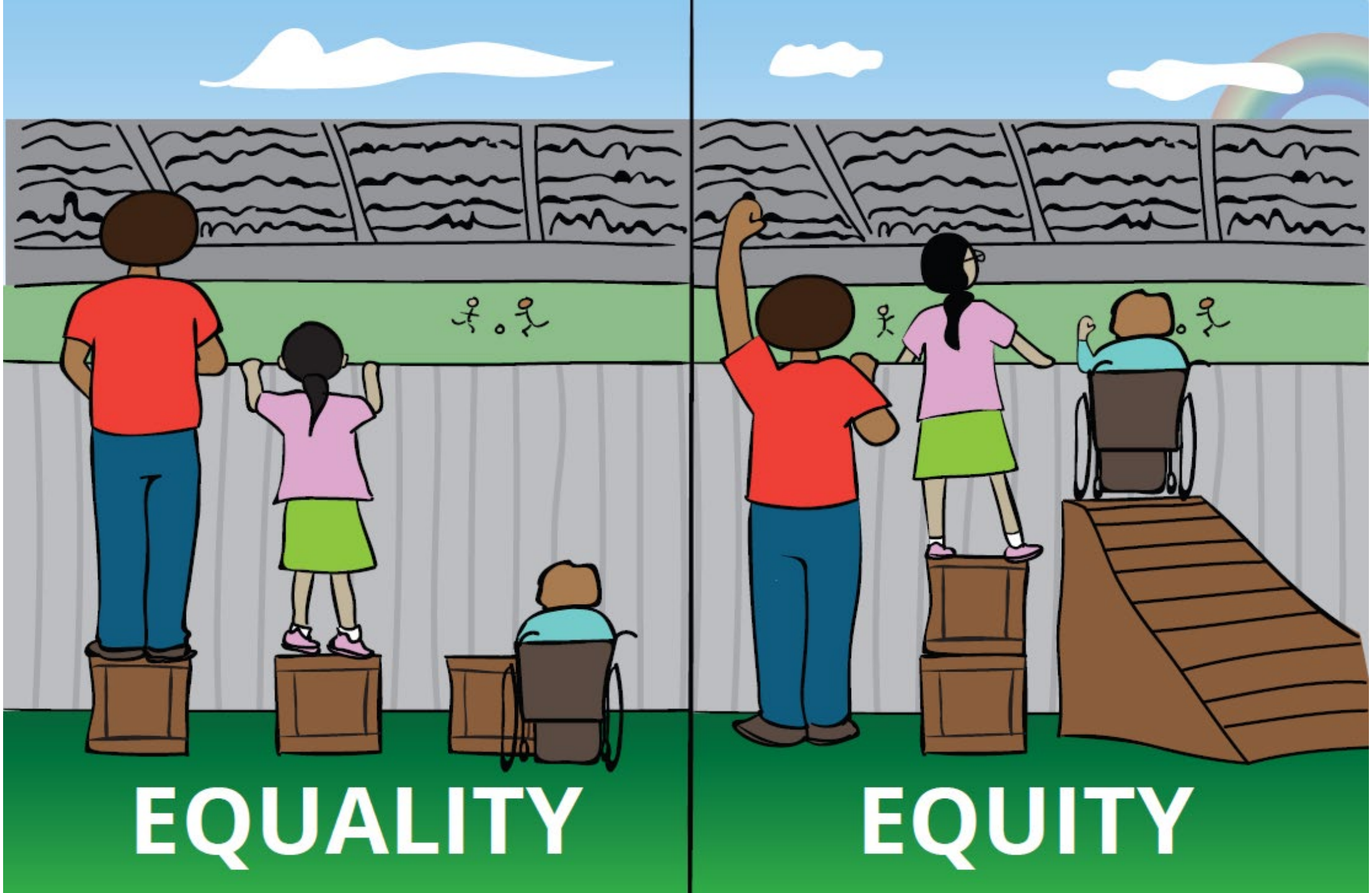
Family PACT California PTC

February 20, 2026

Disclosures

- No financial relationships with pharmaceutical companies
- Gender, sexuality, and family planning are inherently personal and complex


EQUALITY
EQUITY

Learning Objectives:

- Recognize historical and ongoing injustices in reproductive health.
- Apply reproductive justice principles to patient-centered contraceptive counseling and care.
- Compare the safety and effectiveness of tubal sterilization, vasectomy, and long-acting reversible contraceptives.
- Balance patient-centered care with federal consent requirements.
- Identify best practices for referrals and options for procedural training.

High Quality Health Care

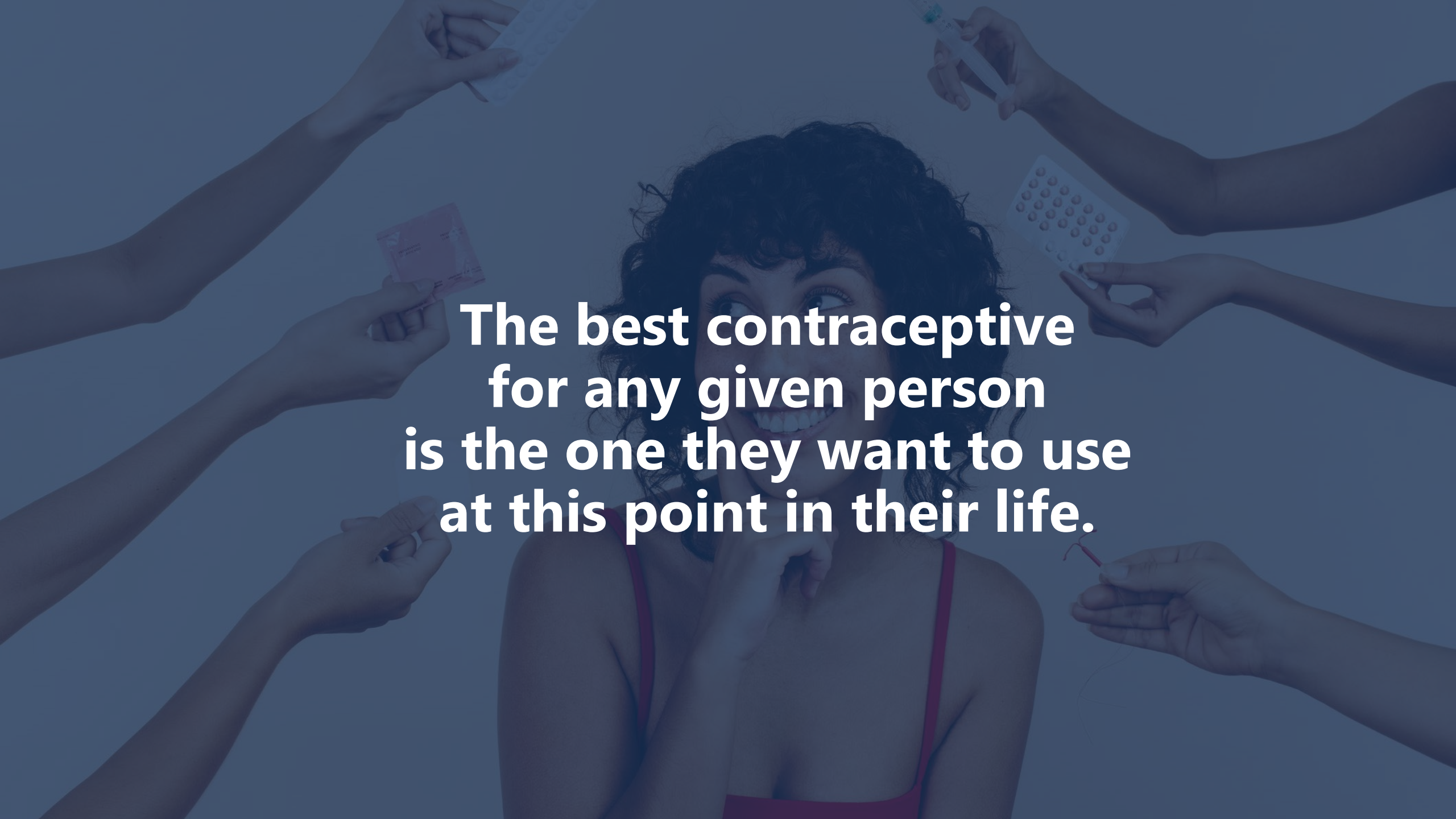
“Doing the right thing
for the right patient,
at the right time,
in the right way
to achieve the
best possible results”

ACCESS to ALL Methods of Birth Control

- Heard of method?
- Talked to a clinician about it?
- Is it safe for YOU?
- Does clinic offer it?
  - Do you know where to go if wanted?
  - How hard would it be to get there?
- Can you afford the method?
- Do you have health insurance?
- Does your plan cover the method?

Begna H et al 2025

PMID: 40780386


The best contraceptive
for any given person
is the one they want to use
at this point in their life.

Cultural Humility

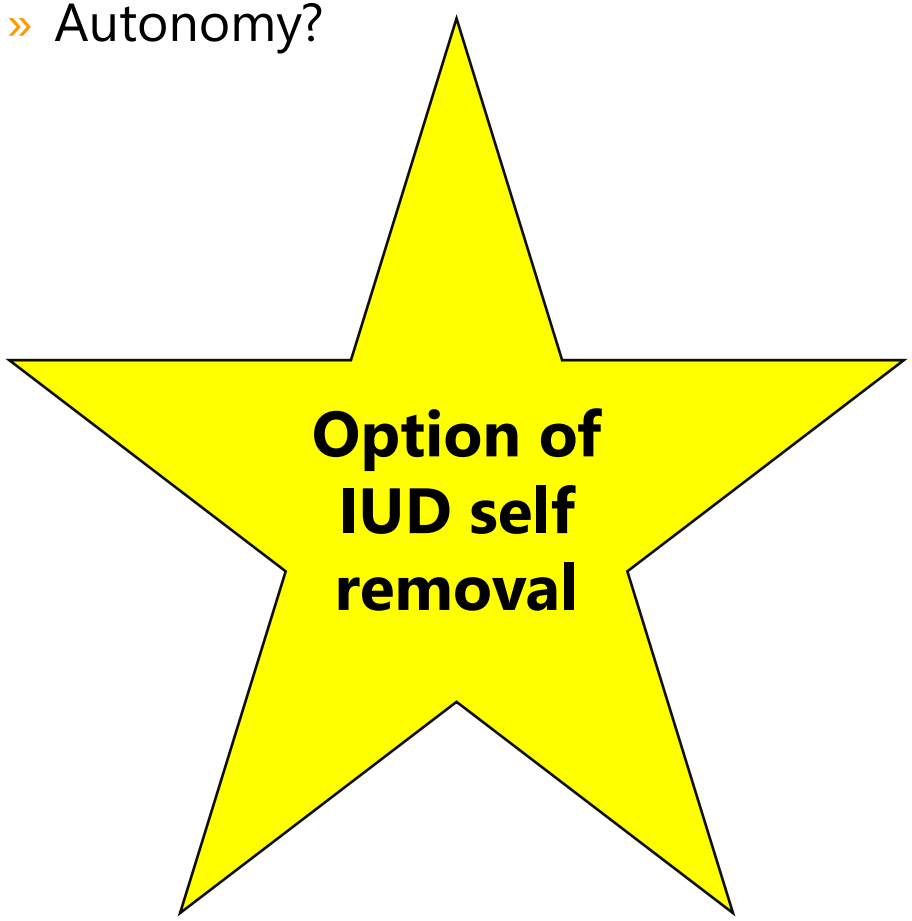
- Avoid assumptions
- Identify patient's personal goals
- Invite to share personal and peer experiences
- Views on fertility vary
- Address internet misinformation
- Be mindful of low literacy and numeracy

Person-Centered Contraceptive Counseling

- Taking my preferences about my birth control seriously
- Giving me enough information to make the best decision about my birth control method
- Respecting me as a person
- Letting me say what mattered to me about my birth control

What Matters to You?

- Acne?
- Bleeding?
- Cancer?
- Confidentiality?
- Convenience?
- Cost?
- Future fertility?
- Libido?
- Mood?
- Pain?
- Safety?
- Weight gain?
- Avoiding abortion?
- Effectiveness?
- Autonomy?



Audience Poll Question #1

What form of birth control is most commonly used in the U.S.?

a) Abortion
b) Pills
c) Condoms
d) Tubal surgery
e) Intrauterine device (IUD)

Surgical contraception is the most common form of birth control used in the U.S.

a) Abortion – 1.16% per year (25% lifetime)

b) Pills –11.4% (21% of contracepting)

c) Condoms – 7.1% (13% of contracepting)

d) Tubal surgery – 11.5% (22% of contracepting)

e) IUD + implants – 10.5% (19% of contracepting)

NSFG 2022-2023

Sterilization Rates Increasing!

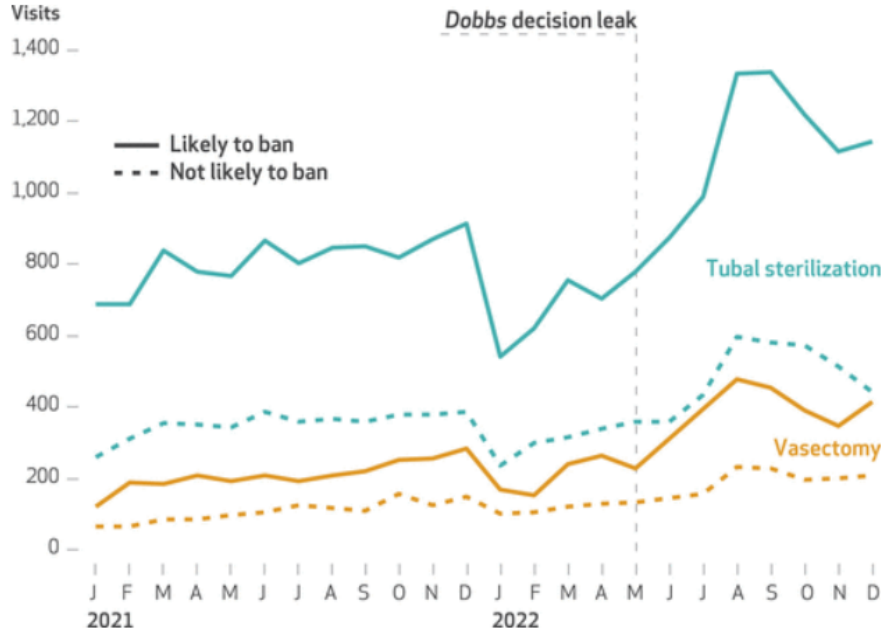
Patel RD, Urol Pract 2025
Nguyen V, et al. Am J Mens Health. 2024

RESEARCH ARTICLE | REPRODUCTIVE HEALTH

HEALTH AFFAIRS > VOL. 44, NO. 1: MEDICARE, MEDICARE ADVANTAGE & MORE

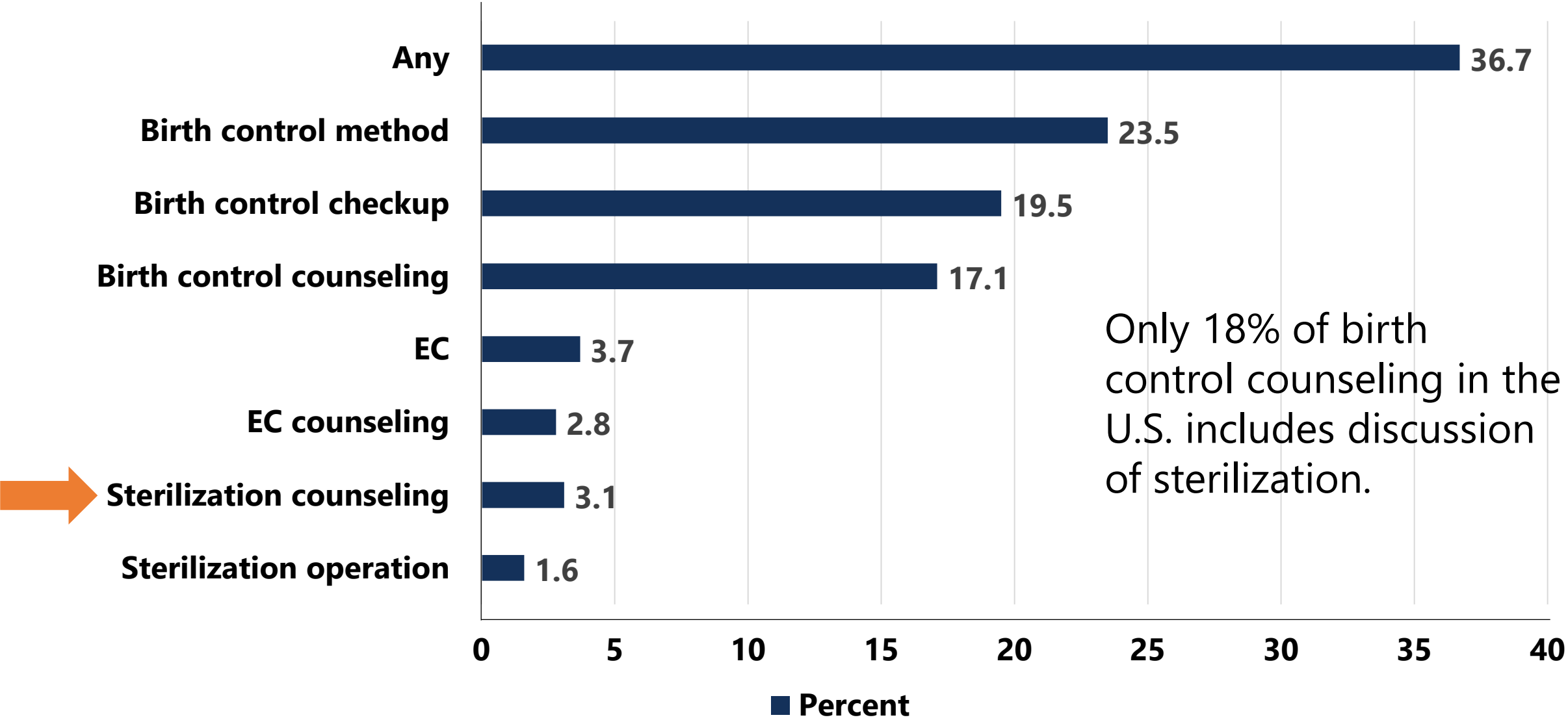
Tubal Sterilization And Vasectomy Increased Among US Young Adults After The *Dobbs* Supreme Court Decision In 2022

Exhibit 1 Tubal sterilization and vasectomy visits for people ages 19–26, by month and likelihood of their state to ban abortion, 2021–22



SOURCE Authors' analysis of IQVIA Dx medical claims data, 2021–22, extracted April 28, 2023.
NOTE At the time of our study, states likely to ban abortion were Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Montana, Nebraska, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, Wisconsin, and Wyoming.

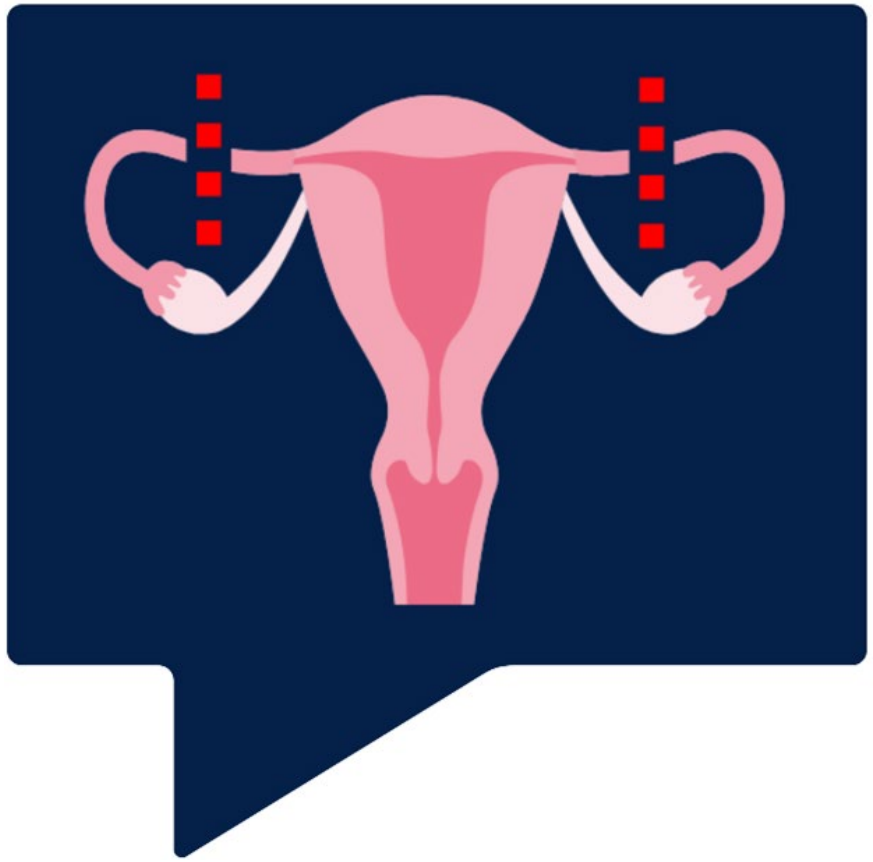
Family planning services in the past 12 months:
% U.S. females 15-49, NSFG 2022-2023



Only 18% of birth control counseling in the U.S. includes discussion of sterilization.

Not Discussed in Sex Ed 101…

Inconsistent and Inaccurate Terminology



- **Having your tubes tied**
- Tubal ligation
- Female sterilization
- Tubal sterilization
- Salpingectomy
- Permanent contraception
- Birth control surgery
- Surgical contraception

Tubes are NOT easy to “untie”!

Despite what Google says

Misperceptions Are Common

- 40% believe easy to reverse tubal surgery
- Only 42% know tubal surgery is NOT easily reversible
- Only 46% believe it will be hard to get pregnant in future if desired
- After reviewing the federal consent form, 34% incorrectly believed sterilization is reversible
- Many still believe IUDs decrease future fertility

Borrero S et al JAMA Netw Open 2024
Advancing Access 2025

Zite 2011, Yee 2011, Treder 2022, Sutton 2021

Audience Poll Question #2

What proportion of U.S. women report regrets after permanent contraceptive surgery?

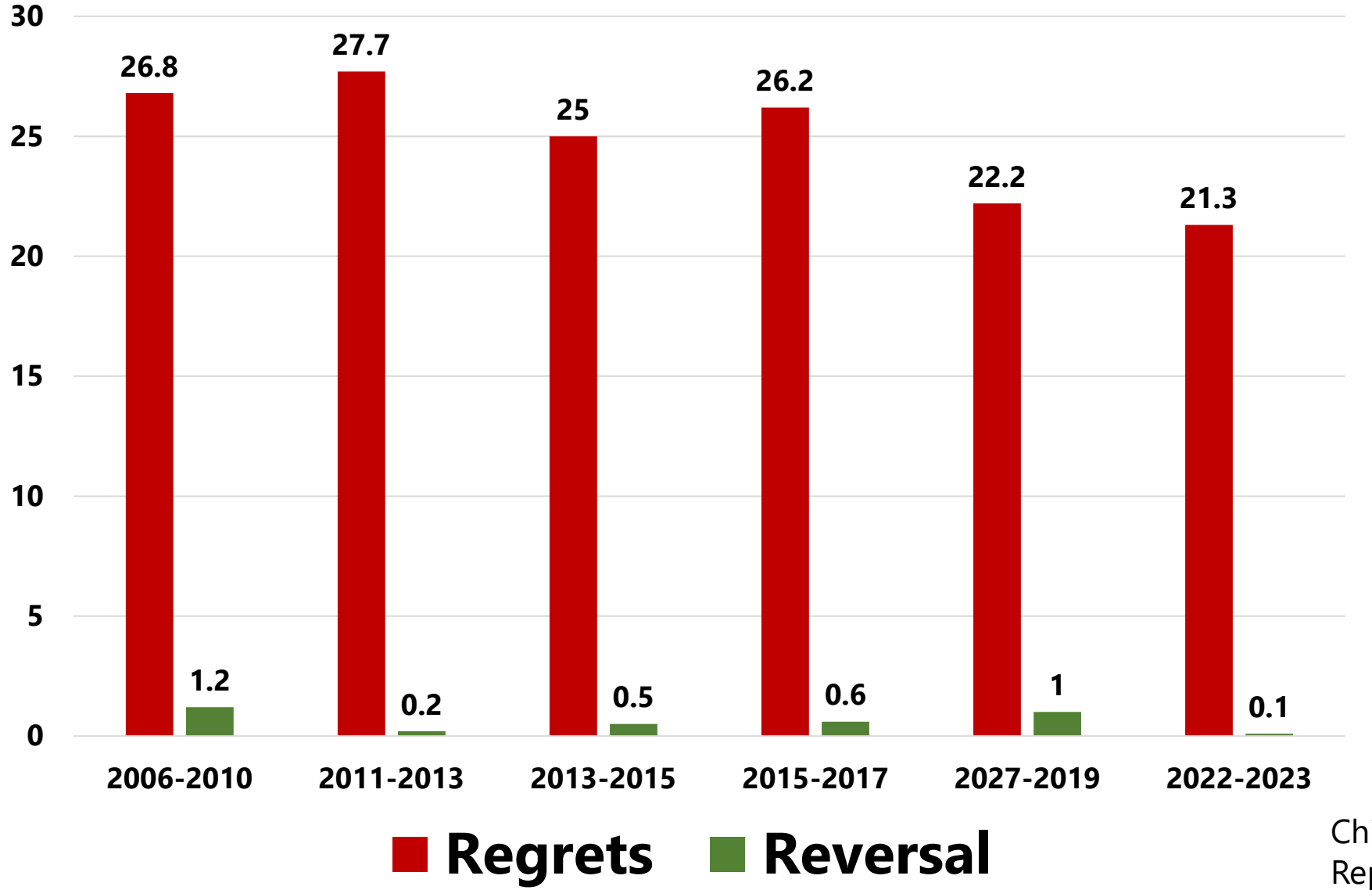
a) 1 out of 100? 1%

b) 1 out of 20? 5%

c) 1 out of 10? 10%

d) 1 out of 5? 20%

Desire for Reversal of Contraceptive Surgery Among U.S. Women



<1% with regrets have "surgery to reverse tubal sterilization"

- Fertility treatments are expensive
- Rarely covered by insurance

Chiang A et al 2026 Fertility & Sterility Reports (NSFG)

What's the safest form of birth control?

I'm SURE I will never want to be pregnant!

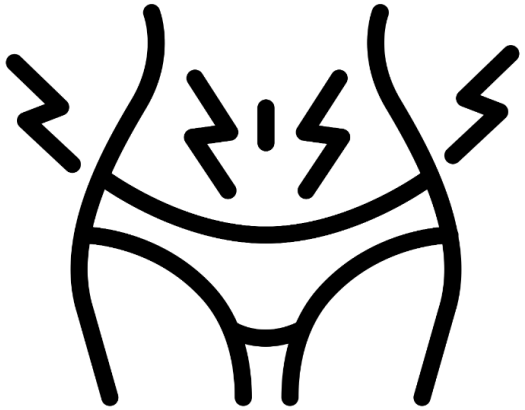
What's the most effective form of birth control?

Safety: Procedural Complications

	Infections	**Bleeding**
Interval Laparoscopic **Tubal Ligation**	3%	0.8%
IUC	0.3%	0.03%
Relative Risk	*10X*	*>20X*

JGIM 2022
PMID: 35194746

Pelvic Pain

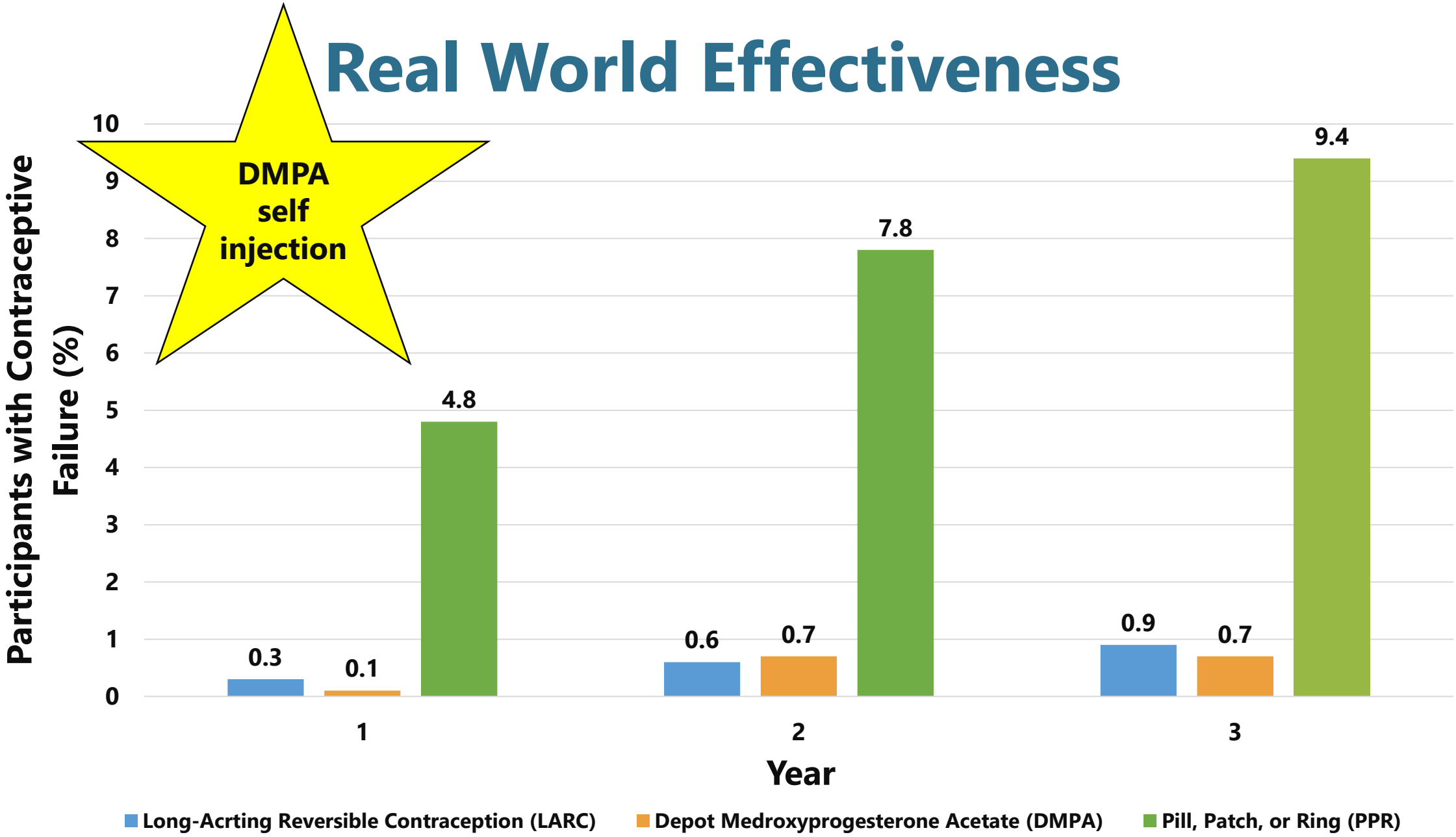


Less common after IUD placement

	Day of procedure	Day 2 to 3 Months	3-6 Months	6-12 Months
Tubal Surgery	19.4%	11.5%	6.6%	9.6%
Hormonal IUD	0.6%	4.5%	3.4%	6.2%

JGIM 2022
PMID: 35194746

Real World Effectiveness



Winner B et al NEJM 2012

Surgical contraception may NOT be the most effective form of birth control for women.

Real World Effectiveness, Medi-Cal Claims Data

Pregnancy Rate Post Procedure	Within 1 Year	3 Years Post Procedures
Laparoscopic Tubal Surgery	2.9%	8.4%

Schwarz, E.B et al (2022). Comparative Effectiveness and Safety of Intrauterine Contraception and Tubal Ligation.. *JGIM*, *37*(16), 4168–4175.

PMID: 35194746

NEJM Evidence

CURRENT ISS

ORIGINAL ARTICLE

Pregnancy after Tubal Sterilization in the United States, 2002 to 2015

Authors: Eleanor Bimla Schwarz, M.D., Amy Yunyu Chiang, Ph.D., Carrie A. Lewis, M.P.H., Aileen M. Gariepy, M.D., and Matthew F. Reeves, M.D. Author Info & Affiliations

Published August 27, 2024 | **NEJM Evid 2024;3(9)** | **DOI: 10.1056/EVIDoa2400023** | **VOL. 3 NO. 9**

Data from National Survey of Family Growth (NSFG)

- 4 independent surveys
- Representative of US women, ages 15-44
  - 2002 data n=7,643
  - 2006-2010 data n=12,279
  - 2011-2013 data n=5,601
  - 2013-2015 data n=5,699

Survival analysis of time to pregnancy

- Censored at tubal reversal, infertility treatment, hysterectomy, bilateral oophorectomy, interview
- Excluded *imputed* post-tubal sterilization conceptions

NEJM Evidence

Published 2024; DOI: 10.1056/EVIDoa2400023

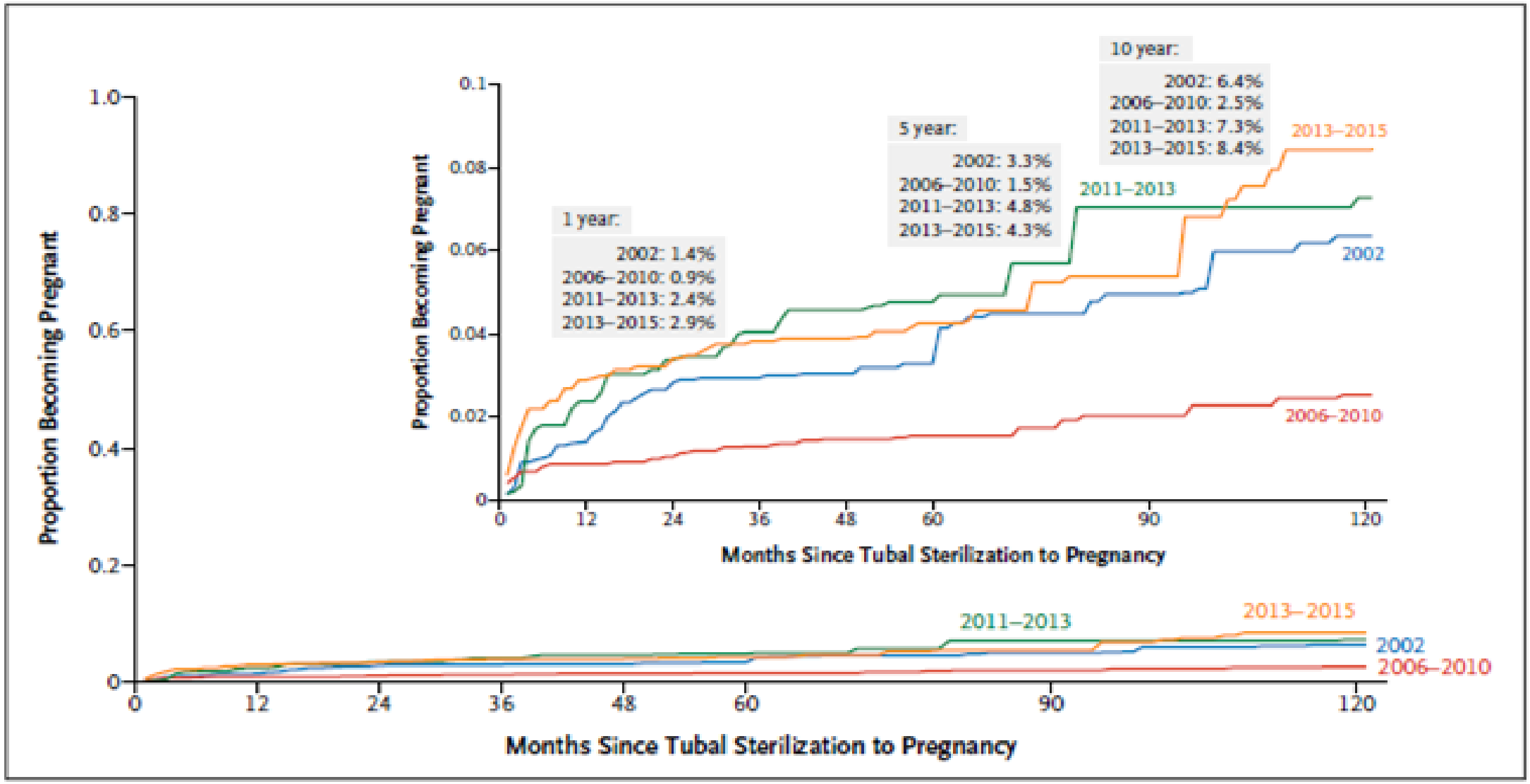


Figure: Cumulative Contraception Failure Resulting in Pregnancy Reported after Tubal Sterilization According to Independent National Survey of Family Growth Waves, 2002-2015

Pregnancy After Tubal Sterilization: NSFG 2002-2015

- Any pregnancy after tubal sterilization?
  - 2.9% to 5.2% of participants across NSFG waves

- In 2013-2015 NSFG:
  - 2.9% pregnant by 12 months after a tubal sterilization
  - 8.4% pregnant by 120 months

Real World Data

	California Medicaid, 2008-2014 Pregnant in 12 months	National Survey of Family Growth, 2013-2015 Pregnant in 12 months
Interval Laparoscopic **Tubal Ligation**	2.6%	2.9%

vs. 1996 CREST trial in academic centers, "<1.5% fail within 5 years"

PMID: 35194746 JGIM 2022
NEJM Evidence 2024

Interval Filshie Clips for Permanent Contraception (Utah Data)

- 1752 permanent contraceptive procedures
- 693 interval placement of Filshie clips
  - **15 pregnancies (2.2% failure rate)**

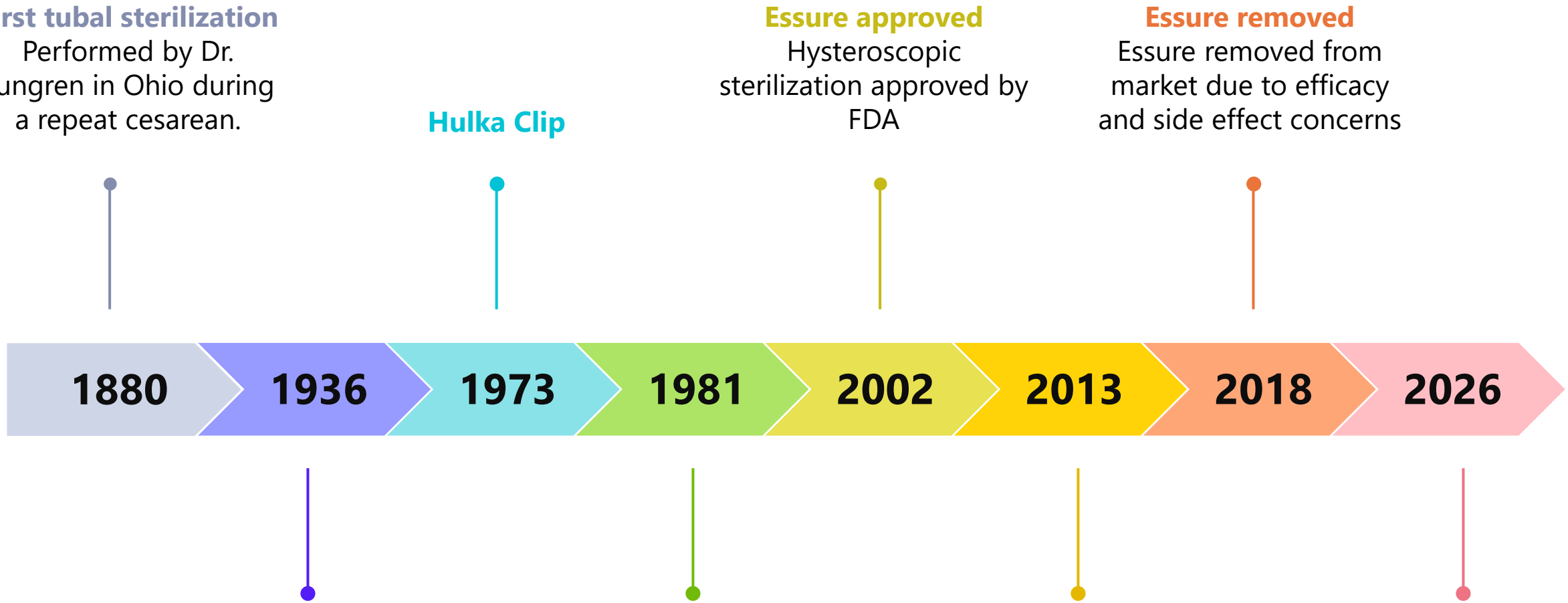
- 547 patients with Filshie Clips used per instructions
- 257 patients with 10 years of follow up data…

Walhof et al. Womens Health Rep. 2021 Jul 27;2(1):279–284.

Conclusion

Tubal sterilization appears less effective than many anticipated.

Tubal Surgery Methods Have Evolved Over Time



First tubal sterilization
Performed by Dr. Lungren in Ohio during a repeat cesarean.

Laparoscopic sterilization

Hulka Clip

Filshie Clip

Essure approved
Hysteroscopic sterilization approved by FDA

Bilateral Salpingectomy
From 2013 to the present, bilateral salpingectomy has become increasingly common

Essure removed
Essure removed from market due to efficacy and side effect concerns

This presentation!
So glad you are here!

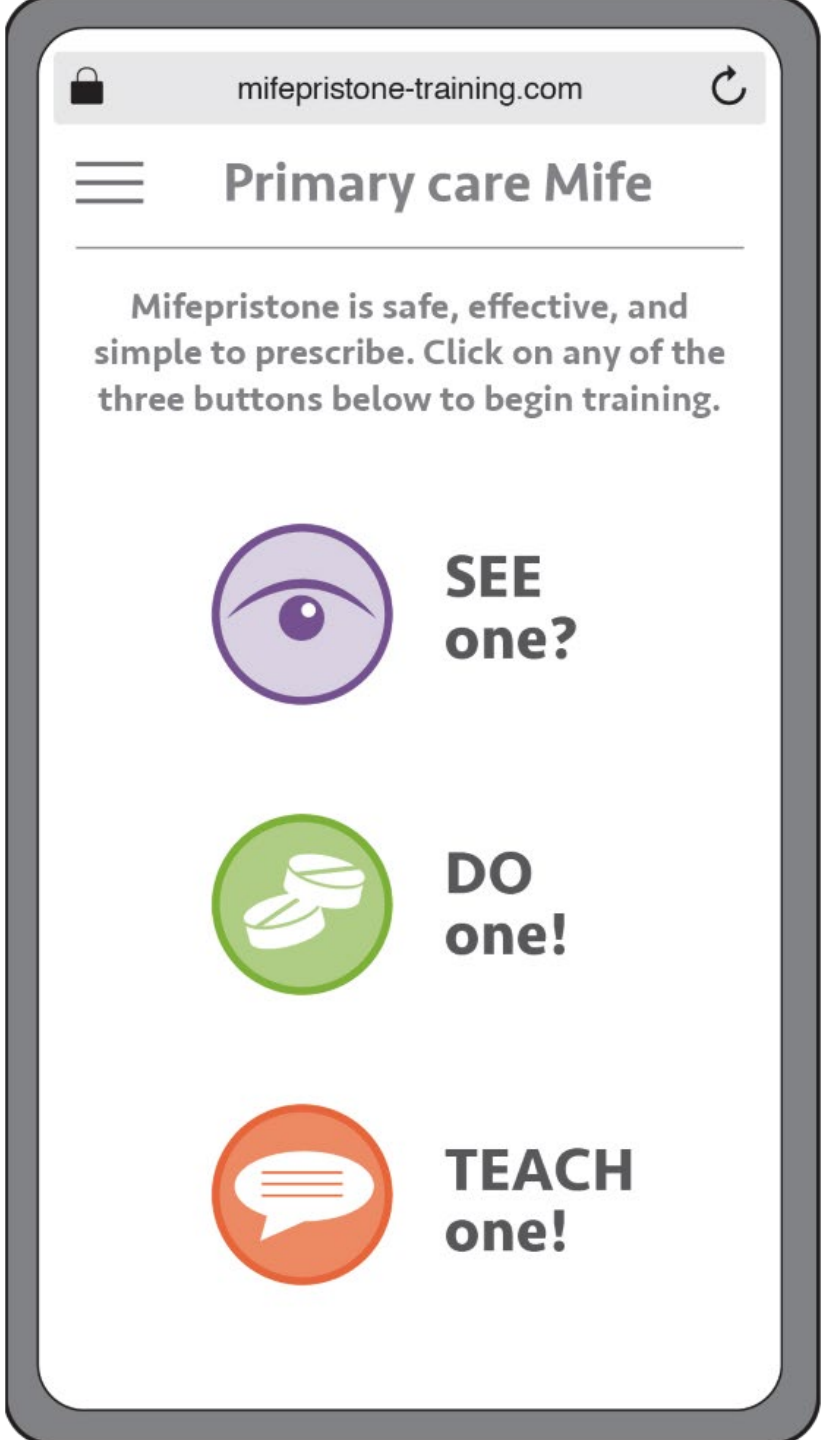
5+ pregnancies reported after bilateral salpingectomy

All forms of contraception have failed.

Lim L, Fuentes H. SAGE Open Med Case Rep. 2024

“Plan C”: Abortion Pills

- Mifepristone 200 mg po
  - Mail order or “certified” pharmacy
- Misoprostol 800 mcg (4 x 200mcg)
  - Sublingually or Vaginally
  - 24-36 hours after mifepristone
  - Ibuprofen 800 mg q6 for 12 hours
- To learn more, visit: https://abortionpillcme.teachtraining.org
- http://PlanCpills.org



www.abortionpillcme.teachtraining/org

FPACT clients who become pregnant are presumptively eligible for Medi-Cal

- prenatal care
- labor, delivery,
- 365 days of postpartum care
- abortion

How Does Surgery Compare to an IUD?

Among California Medi-Cal clients, with contraceptive procedures Jan 2008 and Aug 2014, after adjusting for age, race/ethnicity, region, and multiple other variables, compared to those who had surgery, Medicaid pregnancy-related claims within 12 months

- **Copper IUD had similar rates of pregnancy**
  - Adjusted incident rate ratio (aIRR) 0.92 (0.82–1.05)

- **Hormonal IUD users were 28% LESS likely to be pregnant!**
  - Adjusted incident rate ratio (aIRR) 0.72 (0.64–0.82)

PMID: 35194746
JGIM 2022

Pregnancy-related claims within 12 months of IUC placement compared to tubal surgery

Procedure	Pregnancy rate	Unadjusted IRR (95% CI)	Adjusted* IRR (95% CI)
Laparoscopic tubal ligation	2.64 (2.43-2.86)	Referent	Referent
LNG-IUD	2.40 (2.23-2.59)	0.91 (0.82-1.02)	0.72 (0.64-0.82)
Copper IUC	2.99 (2.76-3.24)	1.13 (1.01-1.27)	0.92 (0.82-1.05)

*Adjusted for age group, race/ethnicity, region, year of procedure, endometrial ablation within 7 days of tubal ligation, Medi-Cal program, months of Medi-Cal enrollment in 2 years pre-procedure (log transformed), and baseline health measures (evidenced by claims in 2 years prior to the index contraceptive procedure indicating obesity, pregnancy (categorized as none, ectopic pregnancy, non-ectopic pregnancy), pelvic inflammatory disease, Charlson comorbidity index, and any contraceptive claims.

Comparing Contraceptive Effectiveness

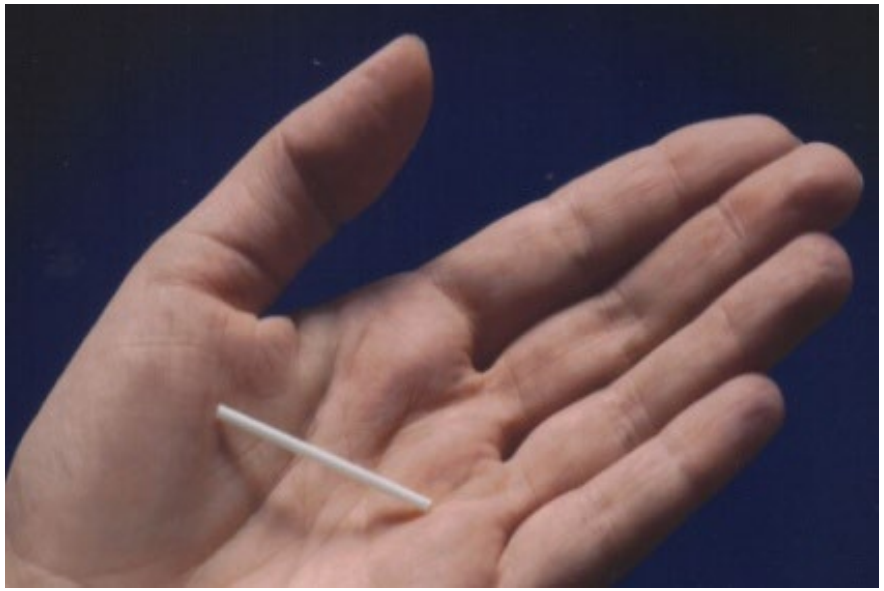
	in 1st year, per 1000 patients
Contraceptive implant	0.2 to 0.5
Vasectomy	1.5
Hormonal IUD	2 to 24
Tubal sterilization surgery	5 to 29
Non-hormonal IUD	8 to 30
Abstinence, periodically	139

Schwarz EB et al NEJM Evidence 2024
Schwarz EB et al JGIM 2022
Polis CB et al Contraception 2026

Nexplanon: Easier than placing an IV

Subdermal Implant

- Single rod of etonogestrel
- No estrogen or blood clots
- Labeled for 3 years, **Effective for 5 years**
- 80% continuation at 1 year
  - Similar to IUDs, better than pills
- Most common reason for discontinuation is spotting



Audience Poll Question #3

When were you trained to place and remove contraceptive implants?

a) In the last year
b) 1-5 years ago
c) 5-10 years ago
d) More than 10 years ago
e) I have not completed the Nexplanon Training.

Audience Poll Question #3

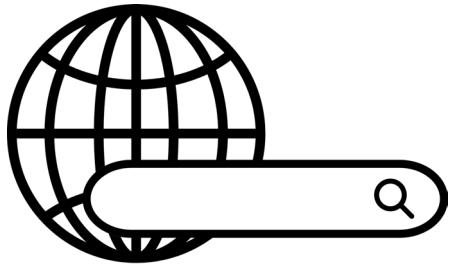
When were you trained to place and remove contraceptive implants?

Still need training?

Sign up today!

https://www.nexplanontraining.com

Web Resources



https://AdvancingAccess.ucsf.edu

https://advancingaccess.ucsf.edu/side-side-chart

English | Español

There is no perfect form of birth control.

Different things matter to different people.

Click on what matters to you and compare methods of long-acting birth control

SAFETY	HOW LONG DO I HAVE TO WAIT?	SIDE EFFECTS
PAIN	RECOVERY TIME	WHAT IF I DON'T LIKE IT?
HOW WELL DOES IT WORK?	BENEFITS	COST

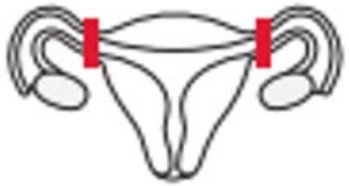
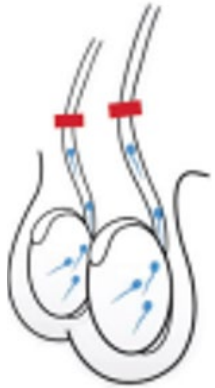
Vasectomy

Vasectomy Counseling

- This is a clinic procedure done with local anesthesia.
- How long does it take to recover from a vasectomy?
- Is vasectomy castration?
- Does vasectomy affect libido?
- Does vasectomy impact erectile function?
- Does vasectomy impact orgasm?
- Does vasectomy cause weight gain?
- Does vasectomy cause prostate cancer?
- How soon is a vasectomy effective?

Arnold JJ et al AFP 2025

Sterilization Methods

Method	How to Use	Impact on Bleeding	Things to Know	How well does it work?
Sterilization: Tubal Methods 	• These methods block or cut the Fallopian tubes. • A clinician reaches the tubes through your belly.	None	• These methods are permanent and highly effective. • Reversal is difficult. • The risks include infection, bleeding, pain, and reactions to anesthesia.	> 98%
Sterilization: Vasectomy 	• A clinician blocks or cuts the tubes that carry sperm from your testicles.	None	• This method is permanent and highly effective. • It is more effective, safer, and cheaper than tubal procedures. Can be done in the clinician's office. • No general anesthesia needed. • Reversal is difficult • Risks include infection, pain, and bleeding. • It takes up to 3 months to work.	> 99%

Typically A 3-Visit Service

1. Intake Visit/Consult

- Patient's goals and perception of vasectomy
- Vasectomy education: procedure, pre- and post-procedure recommendations
- History-taking: medical, social, trauma
- Physical exam
- Informed consent
- Support during procedure
- Determining if the patient is appropriate for outpatient vasectomy

2. Procedure Visit

3. 3-Month Follow-Up

- Checking specimen with microscopy
- Included in vasectomy fee

Shared Decision-Making and Informed Consent

Shared Decision-Making	Informed Consent
Provider holds space to: • Stay connected to the process • Offer options • Consider values and preferences of the patient • Shared evaluation of patient decision, including family input, as appropriate (ACNM, 2022)	Provider: • Maintains awareness of the history of forced sterilization and coercion (Stevens, 2022) • Educates patient about the procedure itself, as well as risks and benefits • Answer questions • Confirms that the patient understands the above • Confirms that the patient is clear and confident in their decision

Vasectomy Consult – History

- Patient preconceptions about vasectomy: mythology, cultural humility
- Genital injury, infections, surgeries; bleeding disorders; anticoagulation therapy; infection risk evaluation
  - Patients with prosthetics, diabetic patients with suboptimal glucose management, and patients taking immunomodulating medications may need a single pre-op dose of an antimicrobial
- History of trauma
  - Healthcare trauma, sexual trauma
  - Person-centered, body-positive, gender-aware, trans- and queer-aware
  - Preparing for patient needs during procedure
- Anxiety
  - Anxiolytic medication
  - Allow space to answer questions, including any follow-up inquiry in weeks before procedure

Vasectomy Consult – Overview of Procedure

- **Safe & effective means of permanent contraception**
- **Overview of procedure**
  - Use of images
  - General description of steps in the process: location of incision, use of anesthetic, how procedure is done and why it works
- **Pre- and post-procedure instructions and expectations**
  - Pre-procedure: +/- trim hair, obtain supportive undergarment, no aspirin x10 days
  - Post-procedure: rest, compression, ice, wound care/dressing, avoid intercourse x 7-10 days
  - Post-vasectomy semen analysis: vasectomy is not permanent right away
    - 25 ejaculations, RTC in 3m, semen sample not more than 60 minutes old
- **Potential complications and when to call**
- **No link between vasectomy and prostate cancer, no link to cardiovascular disease, no change in sexual function or testosterone levels**

Vasectomy Reversal?

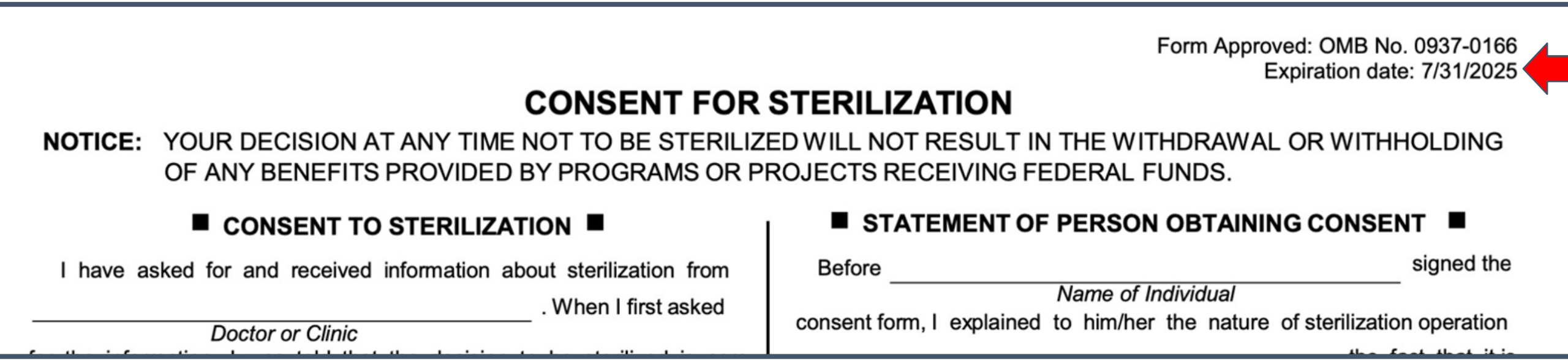
- Patients undergoing vasectomy should expect this to be a permanent option as reversal surgery is not always successful and is costly
- Pregnancy rates after reversal vary widely
- Preoperative factors that predict vasectomy reversal success include patient age, duration of obstructive interval, and female partner age.
  - Older patient age (>40) is associated with lower rates of success
  - The longer it has been since the vasectomy was done, the lower the rate of success
  - Female fertility declines with age and, therefore, so do pregnancy rates

Vasectomy Consult – Exam

- **Physical exam**
  - Trauma-informed: attend to patient comfort and consent during exam
  - Depending on patient history and comfort, it may be an opportunity to educate the patient about bodily/genital self-awareness
  - Locate the vas deferens
  - Assess for anomaly
- Some providers choose to do counseling virtually and do the exam on the day of the procedure, with disclosures that very rarely patients may need to be referred elsewhere

Clients with State/Federal Insurance

Clients who are using state/federal insurance, and their providers, must sign the Consent for Sterilization Form (HHS-687) at least 30 days before the sterilization procedure, but not to exceed 180 days. ***NOTE expiration date on form!***



Form Approved: OMB No. 0937-0166
Expiration date: 7/31/2025

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ . When I first asked
Doctor or Clinic

■ STATEMENT OF PERSON OBTAINING CONSENT ■

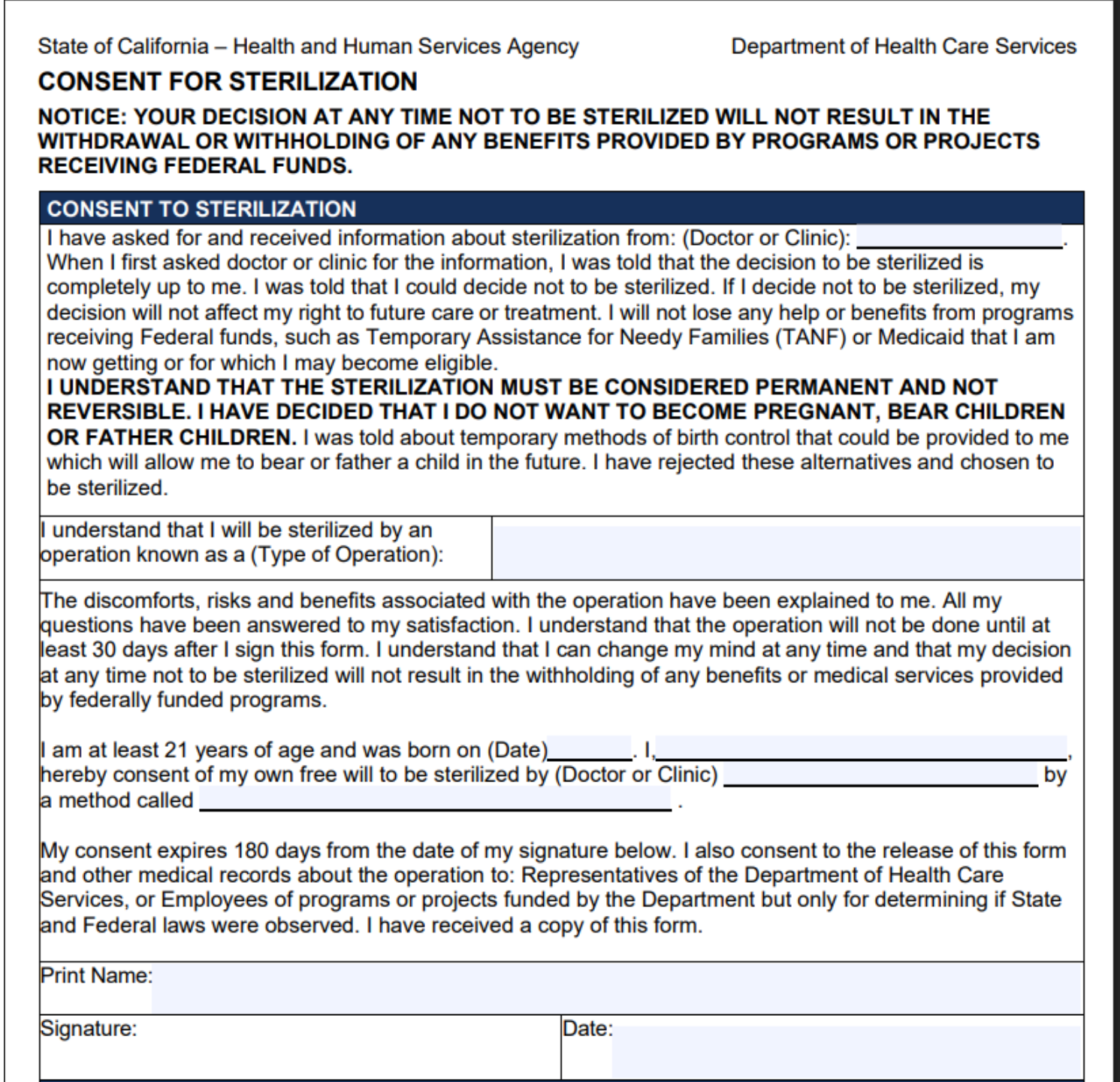
Before _____ signed the
Name of Individual
consent form, I explained to him/her the nature of sterilization operation

Medi-Cal Members & Family PACT Clients

In California, Medi-Cal Members and Family PACT clients must sign the **Consent for Sterilization Form (DHCS 8649**) at least 30 days before the sterilization procedure, but not to exceed 180 days.

DHCS 8649 Form

Medi-Cal Manual – Sterilization



State of California – Health and Human Services Agency Department of Health Care Services

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from: (Doctor or Clinic): _____. When I first asked doctor or clinic for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN. I was told about temporary methods of birth control that could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a (Type of Operation):	

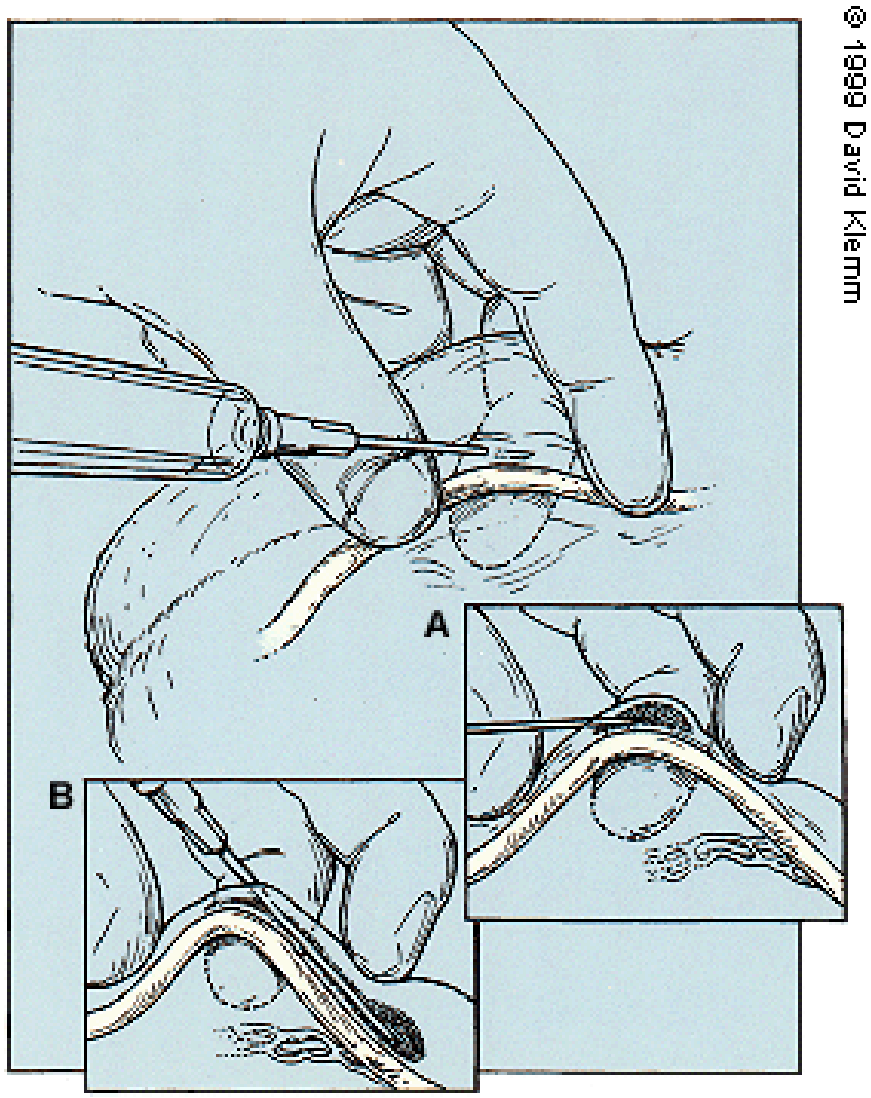
The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction. I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on (Date)_____. I,_____, hereby consent of my own free will to be sterilized by (Doctor or Clinic) _____ by a method called _____ .

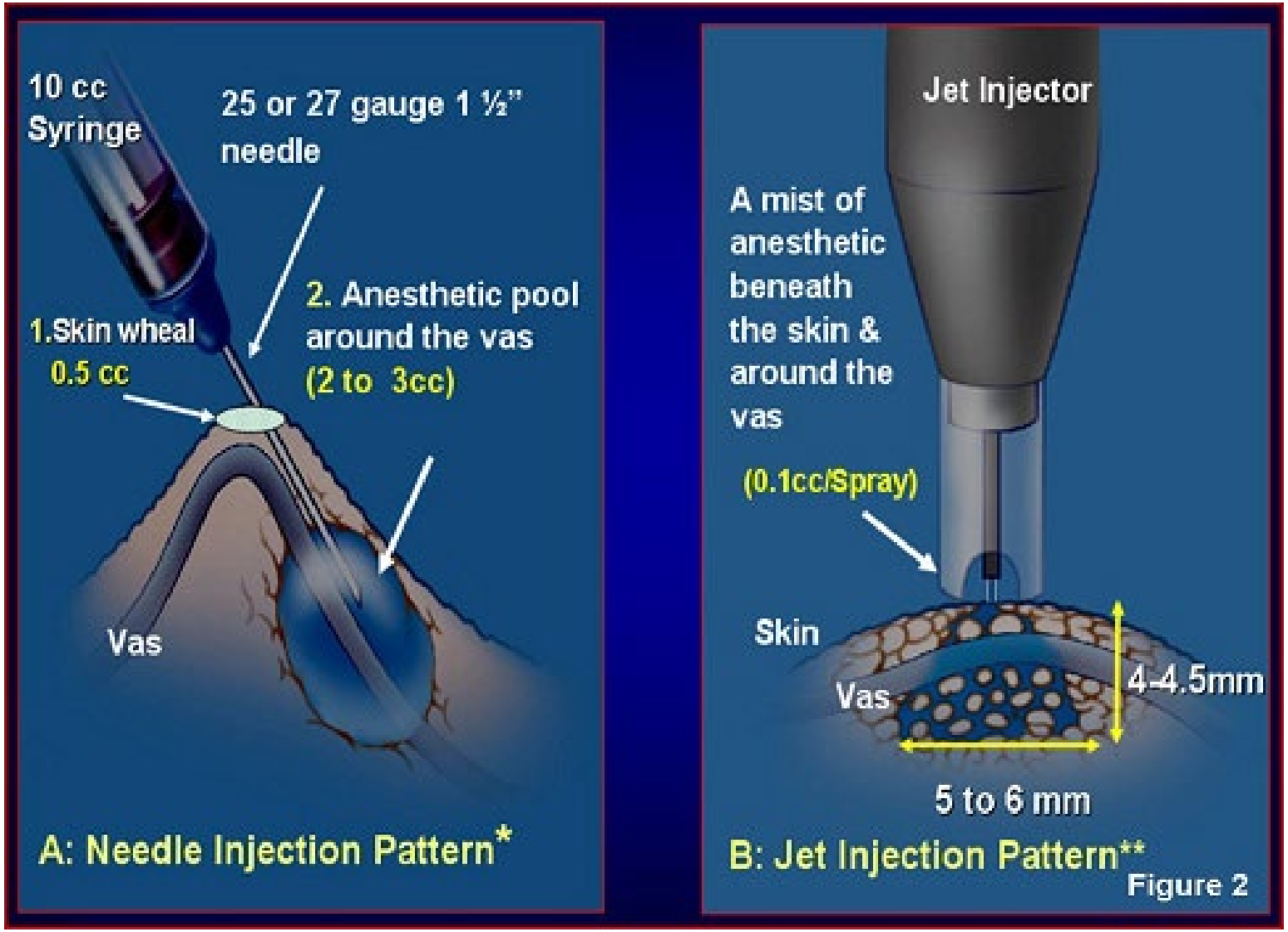
My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health Care Services, or Employees of programs or projects funded by the Department but only for determining if State and Federal laws were observed. I have received a copy of this form.

Print Name:	
Signature:	Date:

Techniques for Local Anesthesia



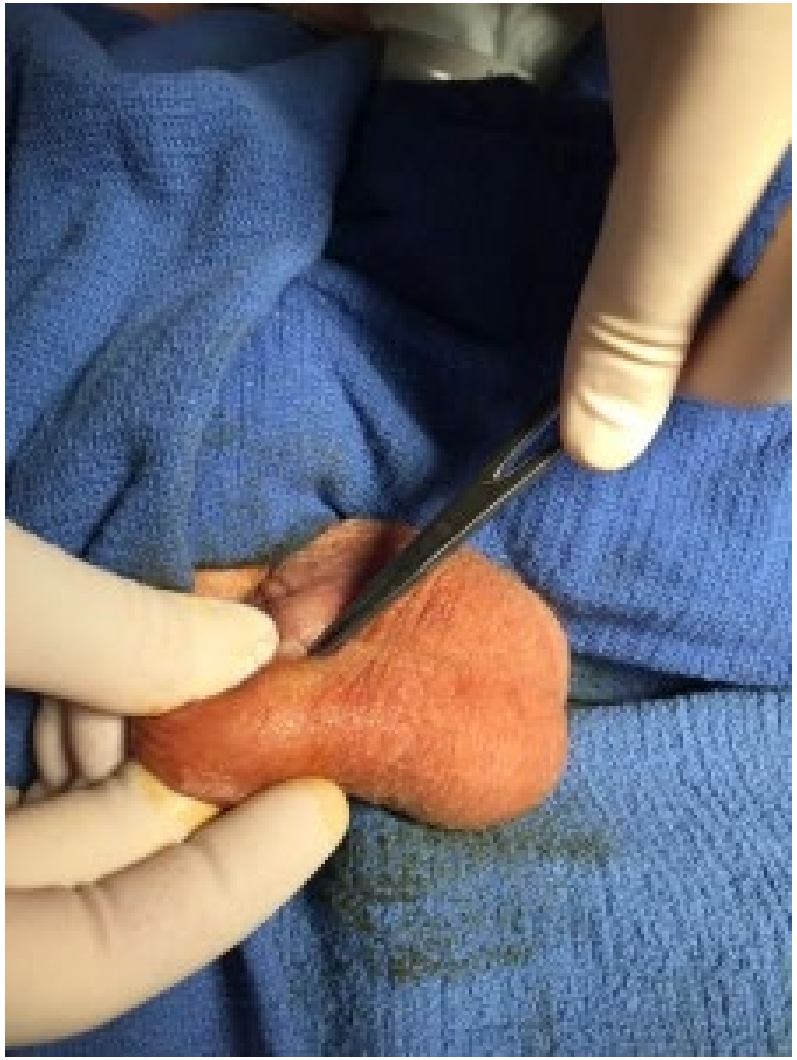
(Clenny & Higgins, 1999)



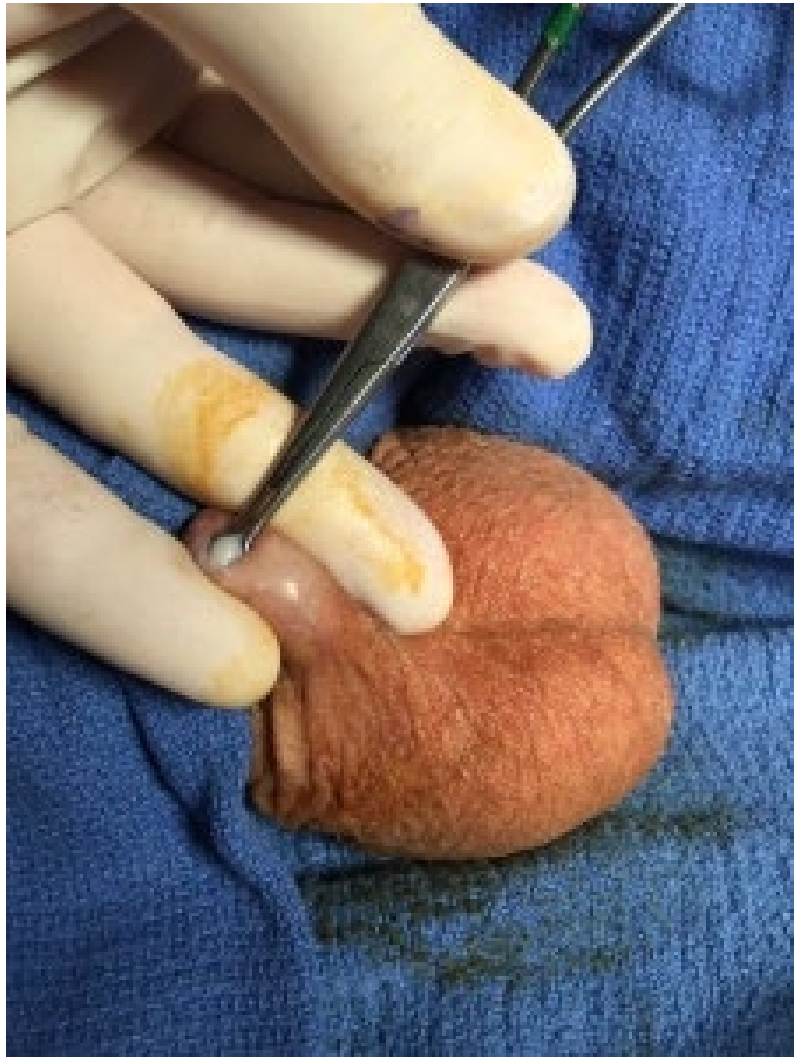
("Urology MadaJet," 2025; Wilson, 2001)

Vas Isolation

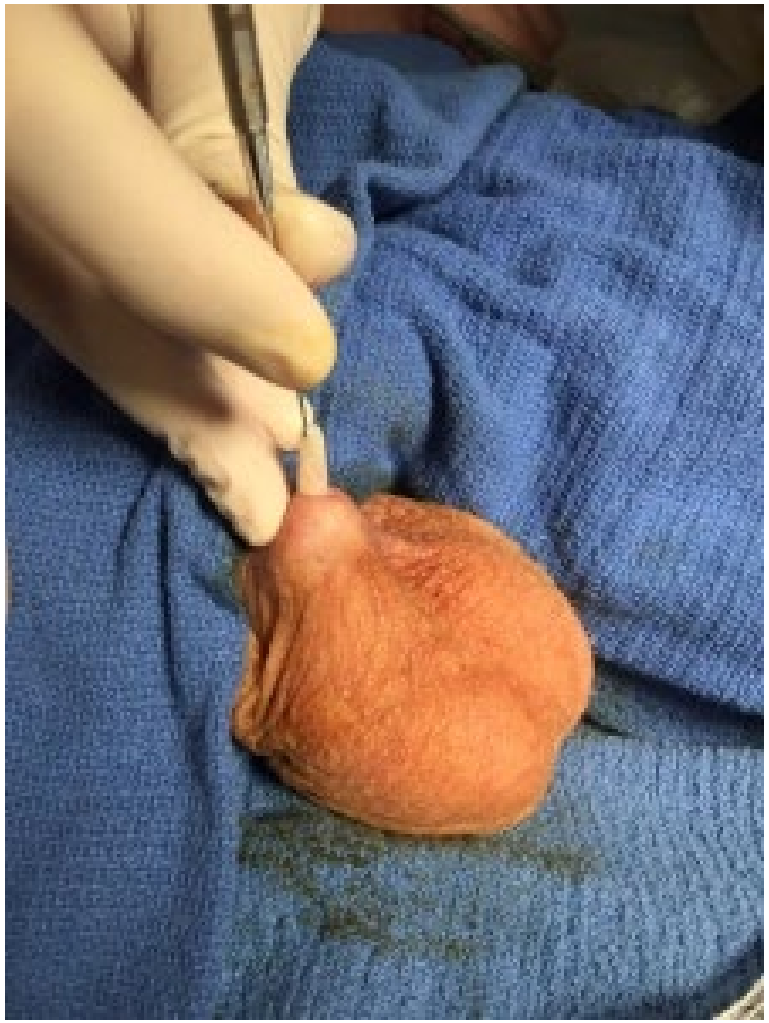
- **Conventional (CV):** single midline or bilateral 1.5cm-3cm incision, vas initially grasped w/ towel clip or Allis forceps
- **No-Scalpel (NSV):** minimally invasive method, must use specific instruments in specific sequential steps, variation on any step = cannot call procedure NSV, incision is typically <10mm
- **Minimally-Invasive (MIV):** any method with minor variation on NSV
- AUA recommends MIV or NSV (moderate recommendation, Grade A evidence)



Creating opening with vas forceps



Grasping vas with ring clamp



Vas is brought up away from scrotal tissue

("Ga Vasectomy in Pictures," n.d.)

Vas Occlusion Techniques

- **Mucosal cautery (MC)** – goal is to create a plug of scar tissue that occludes the vas lumen – can be combined w/ excision, FI, clips
- **Fascial interposition (FI)** – placing a layer of the internal spermatic fascia between the two divided ends of the vas – usually combined w/ other techniques
- **Folding back**
- **Ligation / Clips**

AUA guidelines recommend an occlusive technique that combines MC with FI

- strong recommendation, evidence level: Grade B

Do not use only ligation and short segment excision

- strong recommendation, evidence level: Grade A

(Sharlip, et al., 2012)

Vasectomy Occlusion Techniques

Figure 3A-B. Mucosal Cautery*

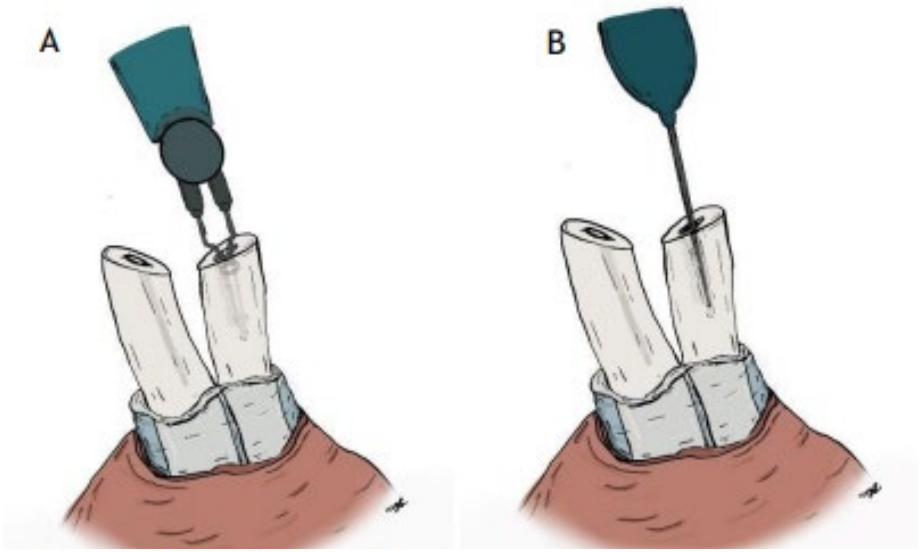


Figure 4A-C. Fascial Interposition*

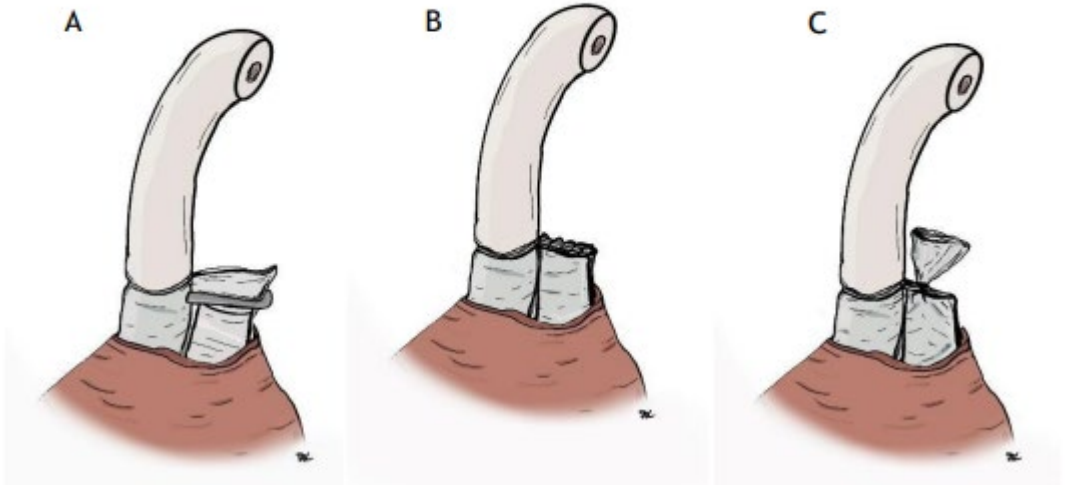
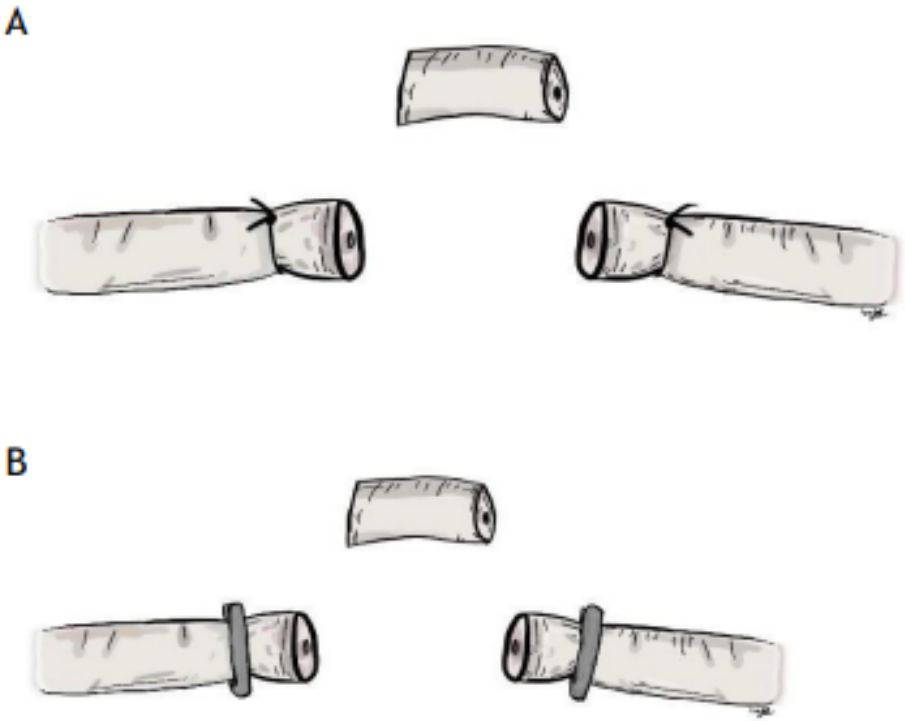
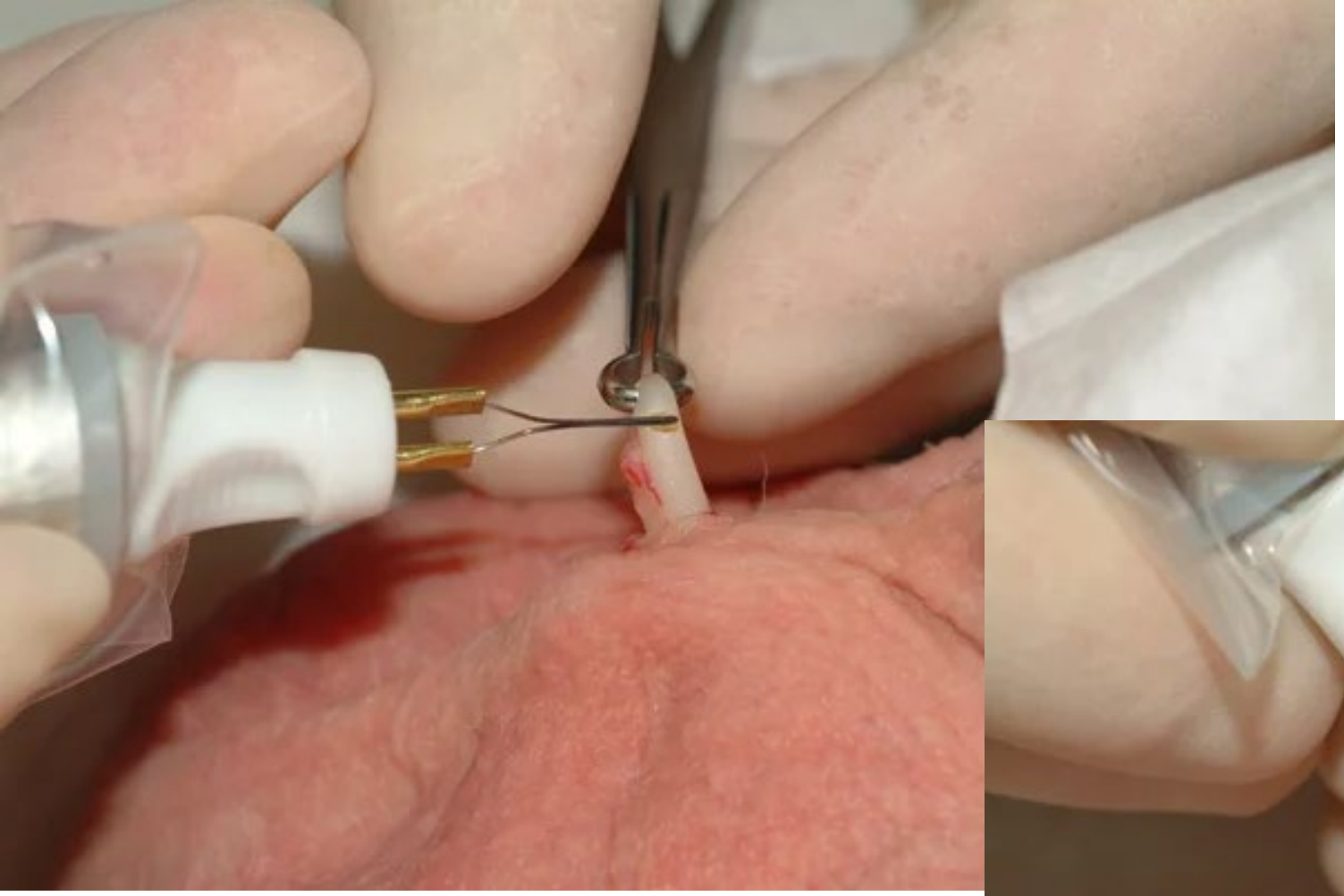
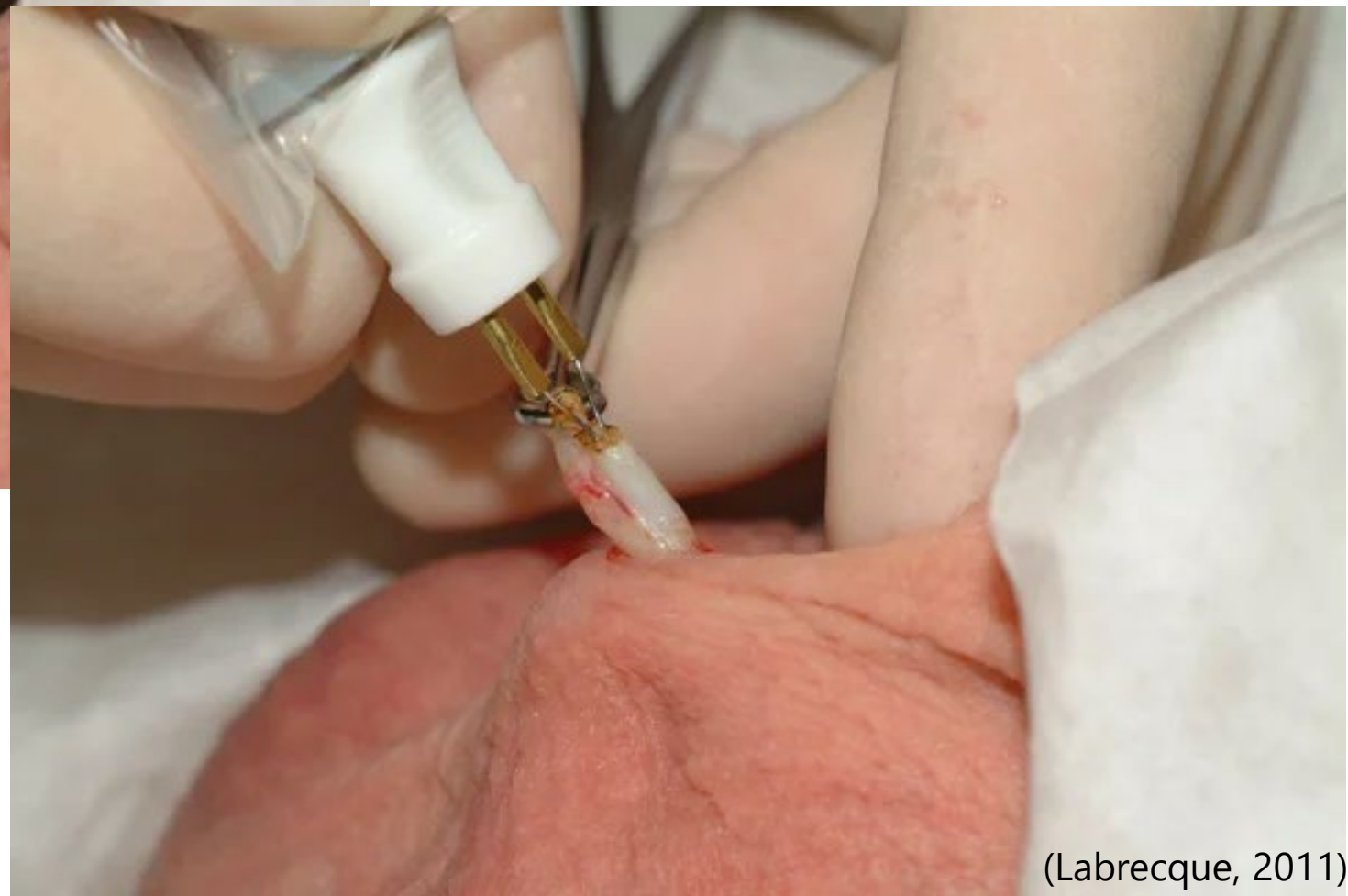


Figure 5. Folding Back*

Figure 6A-B. Ligation and Excision*

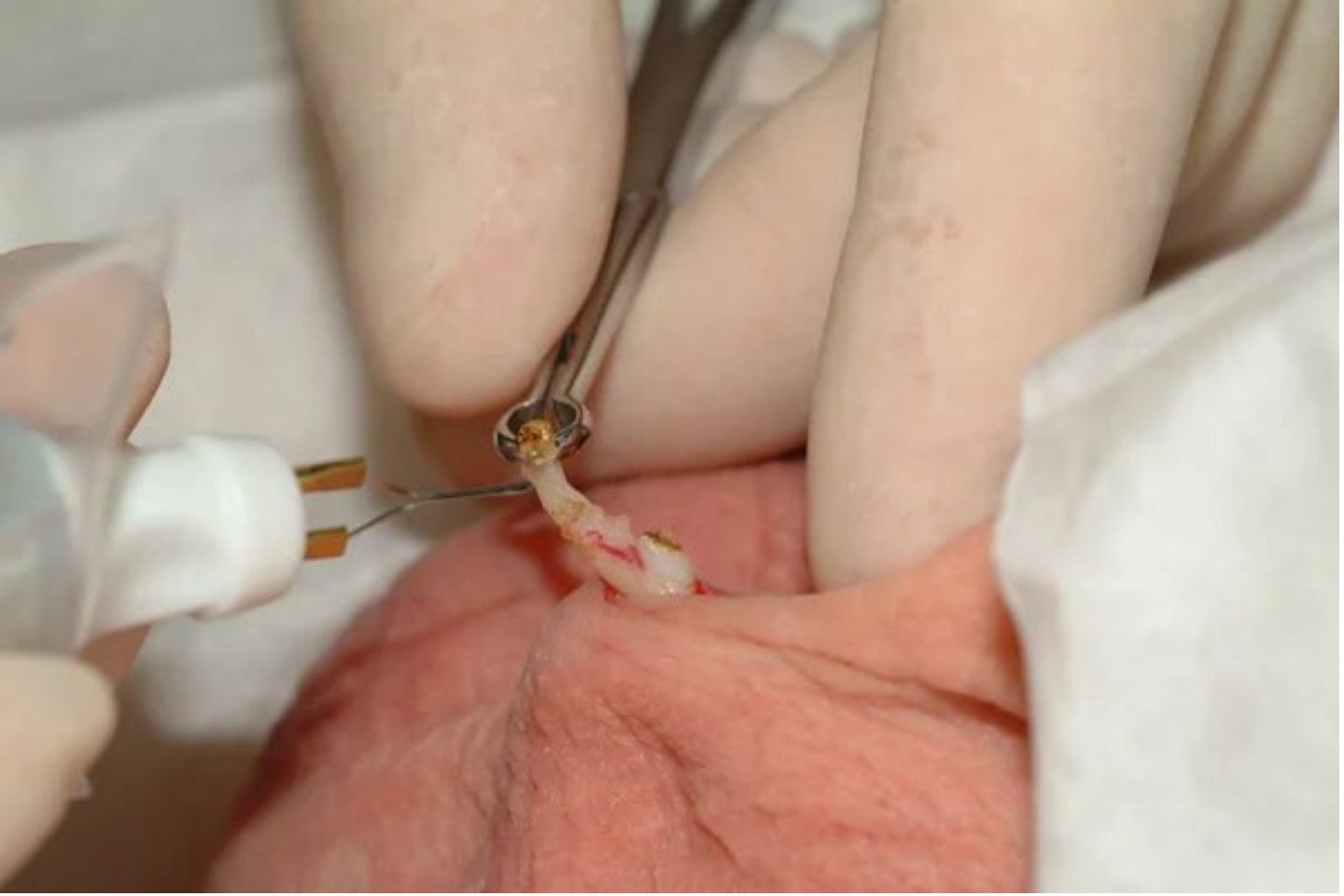


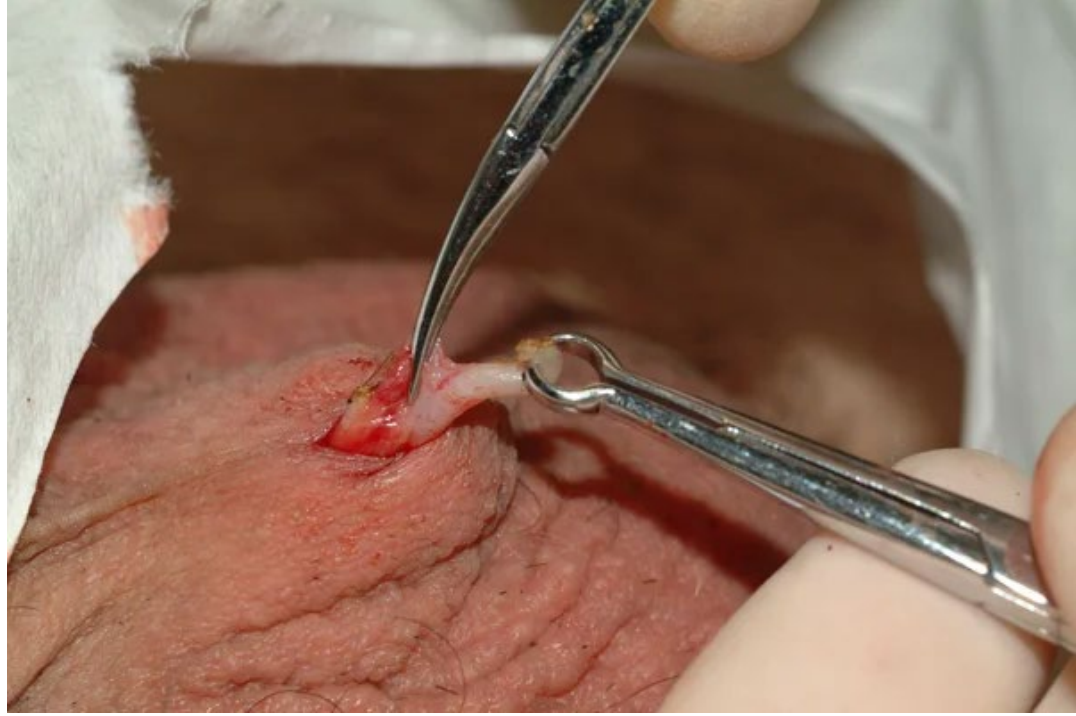


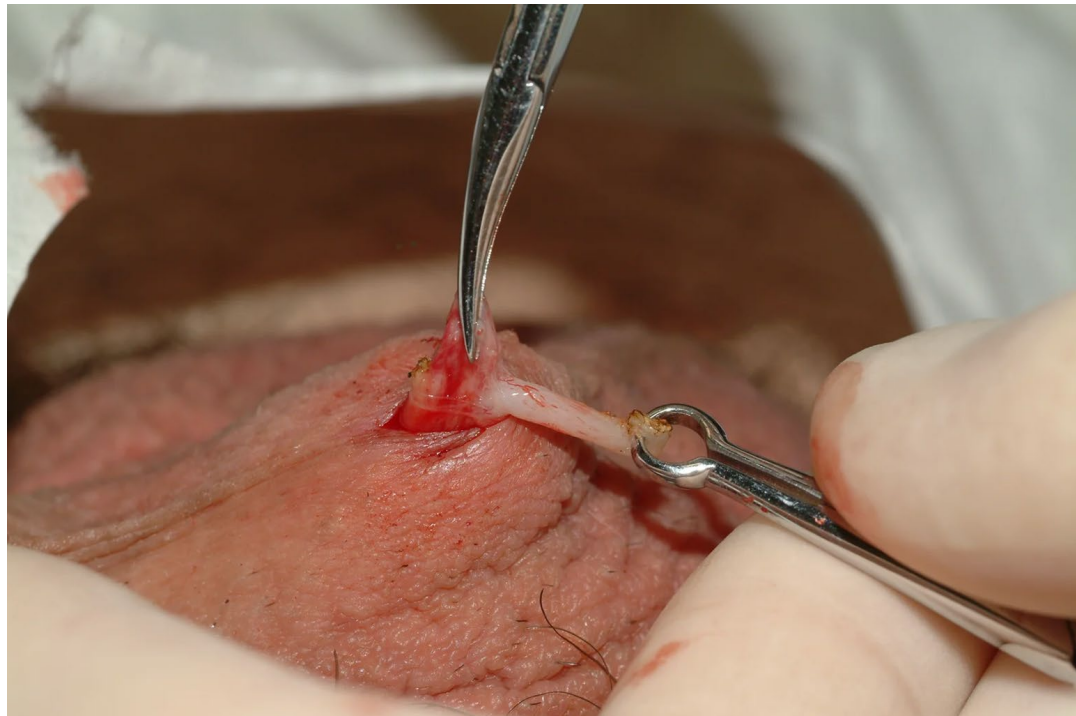


Cautery into the lumen of the abdominal end

(Labrecque, 2011)

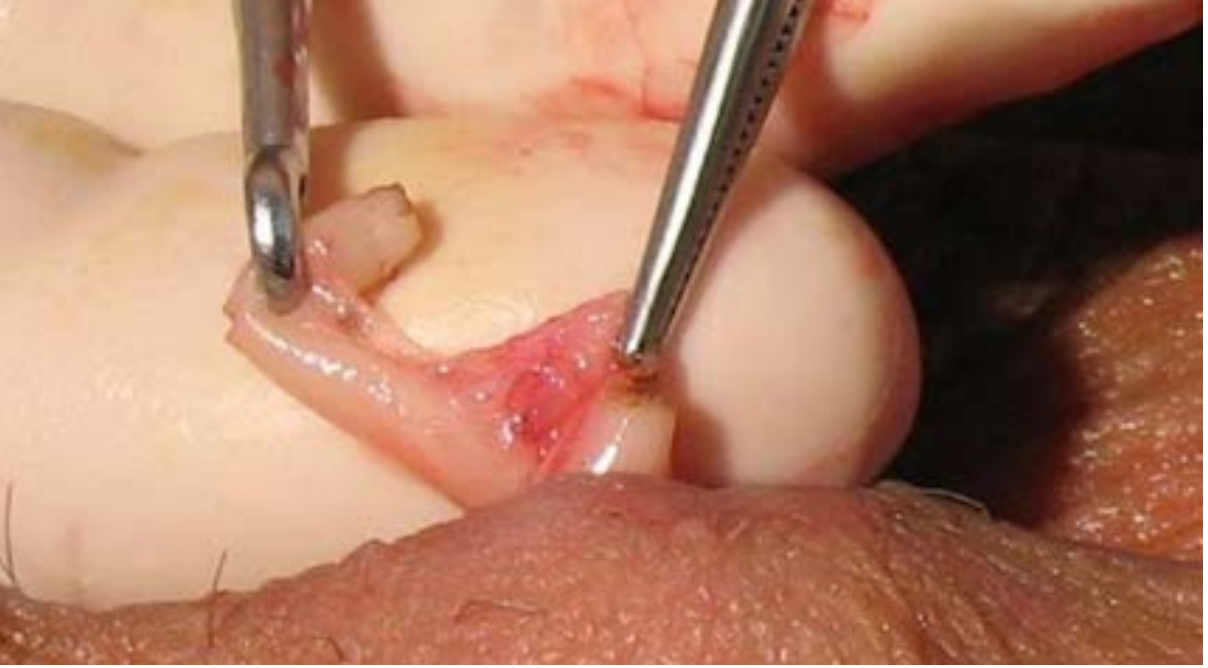


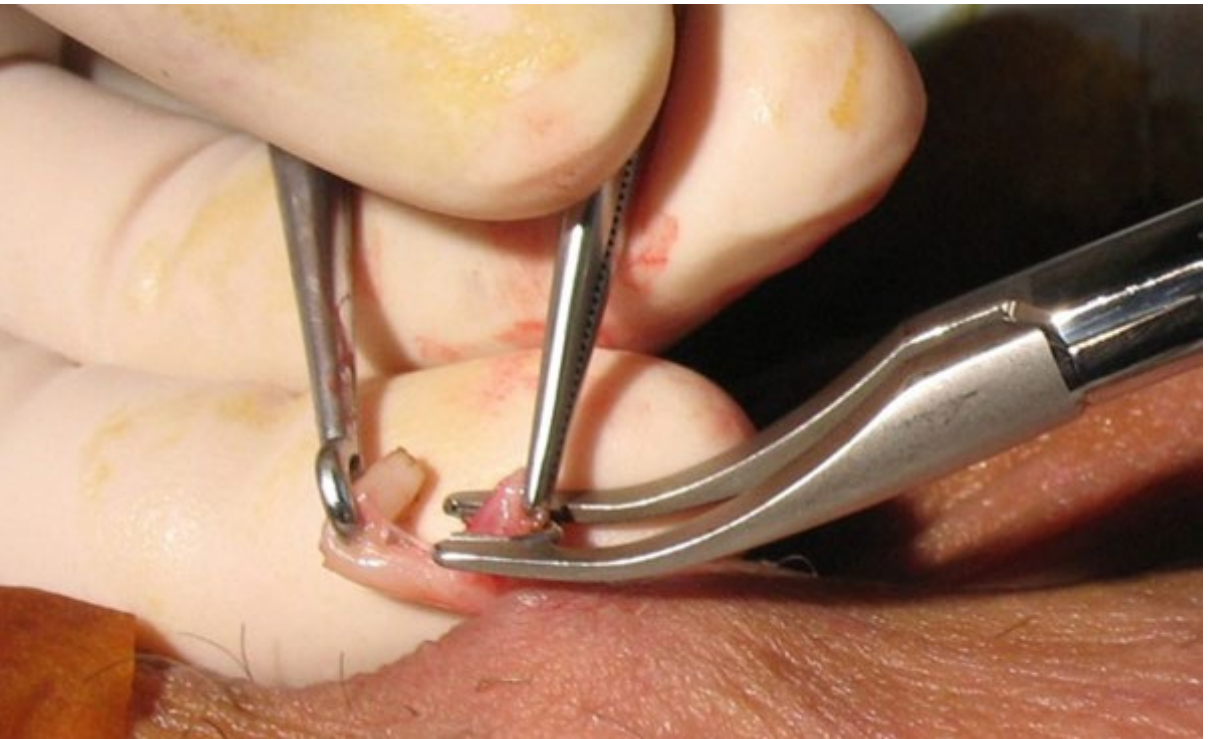


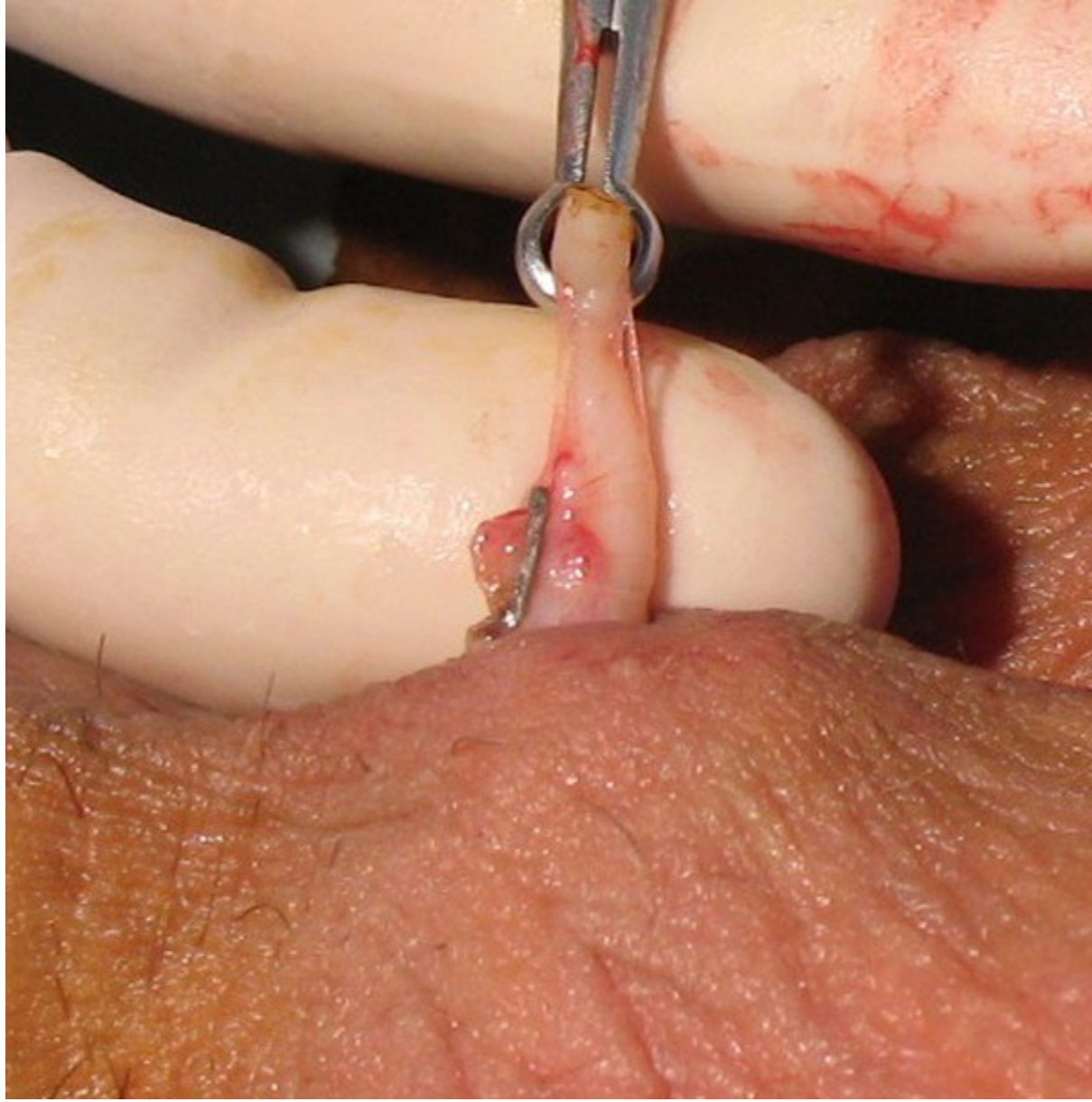


Vas bisected using cautery and then hemostat or vas forceps used to pull fascia up over abdominal end

(Labrecque, 2011)



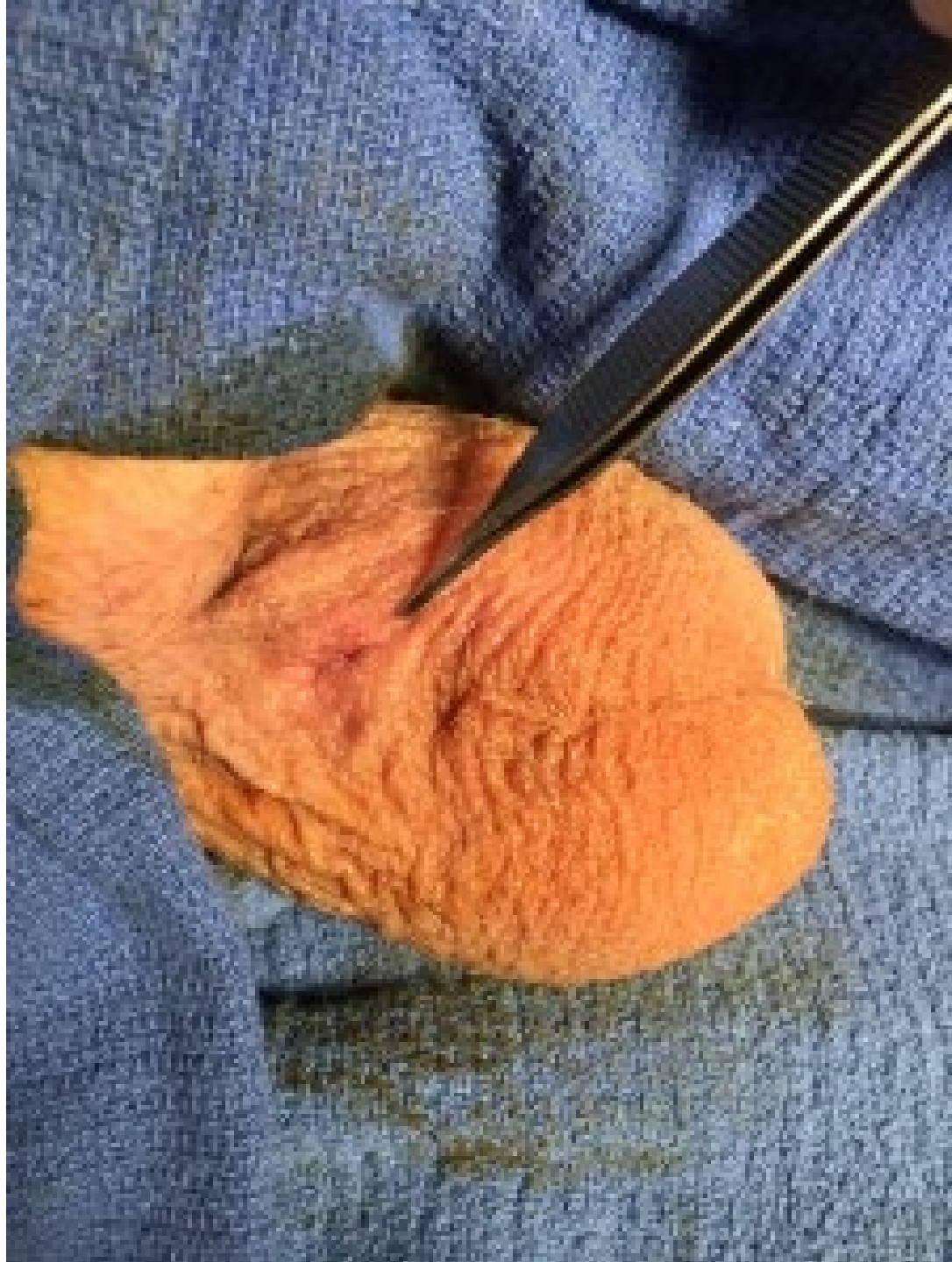




Abdominal end of vas is secured inside fascia, testicular end left open

Post-Procedure Opening

- Often does not require sutures
- Can suture if a larger opening is needed



("Ga Vasectomy in Pictures," n.d.)

Potential Complications

- Bleeding/hematoma
- Incisional infection
- Congestive epididymitis
- Sperm granuloma
- Persistent fertility
- Reactions to local anesthetic agent
- Post-vasectomy pain
- Need for hospitalization

(Viera, 2024; Dassow & Bennett, 2006)

Post-Procedure Follow-Up Guidelines

- Reiterate importance of using backup method of contraception until vasectomy confirmed complete w/ PVSA
- Evaluate sperm motility with fresh, uncentrifuged semen sample <2hrs old
- Can stop using other forms of contraception when PVSA shows azoospermia or only rare non-motile sperm
- PVSA typically performed 8-16 weeks after vasectomy; timing is up to provider
- If motile sperm on 1st PVSA, repeat in 1 month
- Vasectomy is considered a failure if any motile sperm seen on PVSA 6 months post-vasectomy

(Sharlip, 2012)

Benefits of Adding Vasectomy to Your Practice

- Vasectomy accounts for only about 7% of contraception in the US versus tubal ligation at 22% (Patel et al., 2022)
- Increase patient options & satisfaction, reach more patients
  - Minimally invasive
  - Permanent sterilization
  - Low cost
  - Word of mouth: established patients
- Increase revenue possible: setting dependent
- Increase provider job satisfaction
- Change in #s with Dobbs decision and bans

How Do I Add This to My Practice?

- Provider training
- Creating documents
- Staff training
- Work-flow
- Getting paid
- Advertising/marketing
- Start-up budget

Is there the institutional support for adding a new service?

- Administrative/infrastructure details
- Securing funding
- Ensuring team buy-in
- Proper training for all involved
  - Front desk
  - MAs
  - Providers

How I Have Trained Providers

I've been a salaried staff clinician trainer **AND** I've been a contractor trainer.

- Help develop clinical documents
- Review protocols
- Review education materials
- Observe/assist with 3-5 consults
- Observe 3 procedures and begin to assist
- Move to being "lead" on procedure with training clinician as assist
- Learner will assist or perform at least 20 procedures – independence determined by learner comfort and training clinician assessment

Clinical Documents

- Clinic-specific policies/protocols/procedures
- Consent form; your clinic and Medicaid
- Patient education materials: general info, pre-vas and post-vas care, on-call info
- Front desk staff script
- MA script
- On-call script
- EMR templates

Procedure Flow

- Will you use an integrated model interspersed with your other visit types?
- Will you have a designated vas or procedure day?
  - If your team is efficient, you could do 10-15 vasectomies in an 8-hour day
- How many vasectomy kits can you afford to have?
- Time for autoclave to finish cycle
- Could you try the procedure day model for heavy training days and then switch once trained?

Staff Training

- How to schedule appointments
- Counseling patients/doing intake
- Scanning consent forms into EMR
- Room setup
- Kit setup
- Patient preparation
- Assisting clinician
- Room clean up and equipment sterilization
- Proper Billing

Billing

- Intake/Counseling Visit:
  - Z30.09 (Encounter for other general counseling and advice on contraception)
- Vasectomy Visit:
  - Z30.2 (Encounter for sterilization)
  - CPT code: 55250 (Vasectomy)

- In the U.S., the OOP fees range anywhere from $300-$1000 at public health centers and $1000-$3000 in private offices
- Insurance reimbursement varies widely
- Medicaid reimburses most (but not all) states for vasectomy
- Waiting period for Medicaid
- In California, Medi-Cal and Family PACT cover vasectomy
  - Family PACT Providers, refer to the PPBI for coverage details.

Providers

- Identify who will provide this service
- Can APCs in your state do this?
- Budget to send for training
- Trainer:
  - Does someone on-site already provide vasectomy service and training to colleagues?
  - Will you need to hire an outside contractor to train?
- Partnering with other programs
- Medical Director or other local preceptor?
- Referral resource

More Cost Considerations

- Title X sites have certain requirements
- FQHCs and RHCs receive fixed PPS
- How to subsidize fees
- Start-up budget?
- Commercial contract rate?
- Reimbursement allowance?

Advertising and Marketing

- Contract with a temp marketing/communications person?
- Social media
- Radio ads
- Bus station signs, etc.
- Search engine
- Word of mouth
- Clinical staff

Words of Wisdom from the Field

- Cross-organization buy-in
- “Make sure the Medicaid forms are filled out correctly the first time and get to where they need to be”
- “Front desk *must* understand proper scheduling and timing and consent forms”
- Cost of training was not overwhelming
- Creating clinical documents was easy
- “It’s the right thing to do…”
- “We are less expensive than other places.”

Words of Wisdom from the Field, continued

- If you have Title X funding, “dive right in!”
- It’s an asset to have this service on your application.
- Smaller organizations/non-profit: check your liability coverage
- Talking to your board or directors
- Lab component for post vas semen analysis
- Patients ask A LOT about technique, and staff must be educated to answer well
- “If you are ready, do it! There is demand”
- “Well worth the advertising dollars”
- ID key learners internally

Web Resources

- Advancingaccess.ucsf.edu/
- Bedsider.org
- PlanCpills.org
- https://abortionpillcme.teachtraining.org/
- Reproductive Health Access Project
- https://www.auanet.org/guidelines-and-quality/guidelines/vasectomy-guideline

GENDER IDENTITY IS

RACIAL JUSTICE IS

ENDING INCARCERATION IS

SUPPORTING TEEN PARENTS IS

FREEDOM FROM VIOLENCE IS

BUILDING FAMILY ON YOUR OWN TERMS IS

ENVIRONMENTAL JUSTICE IS

ACCESSIBLE ABORTION IS

DISABILITY JUSTICE IS

SUPPORTING BIRTHPARENTS IS

PAID LEAVE IS

QUEER FAMILIES ARE

SAFE COMMUNITIES ARE

DECOLONIZATION IS

Thank you!

Questions?
Comments?
Collaboration?

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES